(1) No. 02-5664-CFY Title: Charles Thomas Sell, Petitioner
v.
United States

Docketed: August 7, 2002 Court: United States Court of Appeals for the Eighth Circuit

Entry	Date	Proceedings and Orders
	Aug 2 2002	Petition for writ of certiorari and motion for leave to proceed in forma pauperis filed. (Response due October 7, 2002)
	Aug 19 2002	Brief amicus curiae of Center for Cognitive Liberty & Ethics filed.
	Aug 20 2002	Order extending time to file response to petition until October 7, 2002.
	Sep 3 2002	Brief amicus curiae of National Assoc. of Criminal Defense Lawyers filed.
	Oct 4 2002	Brief amici curiae of Association of American Physicians & Surgeons, et al. filed.
	Oct 7 2002	Brief of respondent United States in opposition filed.
	Oct 7 2002	Brief amicus curiae of American Civil Liberties Union of Eastern Missouri filed.
	Oct 7 2002	Motion of Law Office of Julie Ruiz-Sierra for leave to file a brief as amicus curiae filed.
	Oct 17 2002	DISTRIBUTED for Conference of November 1, 2002
	Nov 4 2002	REDISTRIBUTED for Conference of November 8, 2002
	Nov 4 2002	Petition GRANTED. The motion of petitioner for leave to proceed in forma pauperis is granted. The motion of Law Office of Julie Ruiz-Sierra for leave to file a brief as amicus curiae is denied. The petition for a writ of certiorari is granted limited to the following question: Whether the Court of Appeals erred in rejecting petitioner's argument that allowing the government to administer antipsychotic medication against his will solely to render him competent to stand trial for non-violent offenses would violate his rights under the First, Fifth, and Sixth Amendments. SET FOR ARGUMENT March 3, 2003. **********
	Nov 21 2002	Motion of petitioner for appointment of counsel filed.
	Dec 9 2002	Motion DISTRIBUTED. December 13, 2002 (page 16)
	Dec 16 2002	Motion for appointment of counsel GRANTED and it is ordered that Barry A. Short, Esquire, of St. Louis, Missouri is appointed to serve as counsel for the petitioner in this case.
	Dec 17 2002	Joint appendix filed.
	Dec 17 2002	Brief of petitioner Charles T. Sell filed.
	Dec 19 2002	Brief amicus curiae of National Association of Criminal Defense Lawyers filed.
	Dec 19 2002	Brief amicus curiae of American Civil Liberties Union of Eastern Missouri filed.
	Dec 19 2002	Brief amicus curiae of Rutherford Institute filed.
	Dec 19 2002	Brief amicus curiae of Center for Cognitive Liberty & Ethics filed.

APP

No. 02-5664-CFY

Entry	Date	Proceedings and Orders
	Dec 19 2002	Motion of Drug Policy Alliance for leave to file a brief as amicus curiae filed.
	Dec 19 2002	Motion of American Psychological Association, et al. for leave to file a brief as amici curiae filed.
	Dec 19 2002	Brief amicus curiae of NY State Association of Criminal Defense Lawyers filed.
	Jan 13 2003	Motion of Drug Policy Alliance for leave to file a brief as amicus curiae GRANTED.
	Jan 13 2003	Motion of American Psychological Association, et al. for leave to file a brief as amici curiae GRANTED.
	Jan 22 2003	Record filed.
	Jan 22 2003	Brief of respondent United States filed.
	Jan 22 2003	Motion of American Psychiatric Association, et al. for leave to file a brief as amici curiae filed.
	Jan 23 2003	CIRCULATED.
	Feb 21 2003	Reply brief of petitioner Charles T. Sell filed.
	Feb 24 2003	Motion of American Psychiatric Association, et al. for leave to file a brief as amici curiae GRANTED.
	Feb 28 2003	Counsel should be prepared to discuss the jurisdiction of this Court and of the Court of Appeals in this case, see Cohen v. Beneficial Industrial Loan, Corp., 337 U.S. 541 (1949), and are directed to file with the Clerk, and serve upon opposing counsel, supplemental briefs on the issue on or before 3 p.m., Friday, March 7, 2003. Twenty copies of the briefs prepared under this Court's Rule33.2 may be filed initially in order to meet the March 7 filing date. Rule 29.2 does not apply. Forty copies of the briefs prepared under Rule 33.1 are to be filed as soon as possible thereafter.
	Mar 3 2003	ARGUED.
	Mar 4 2003	Motion of United States for leave to exceed the supplemental brief page limitation filed.
	Mar 4 2003	Supplemental brief of respondent United States (TBP) filed.

02 No. 5661

ORIGINAL

Supreme Court, U.S.
FILED
NOV 2 2002
CLERK

IN THE SUPREME COURT OF THE UNITED STATES

DR. CHARLES THOMAS SELL, D.D.S.
Petitioner,

v.

THE UNITED STATES OF AMERICA
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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84 pp

QUESTIONS PRESENTED

1. Whether the government can violate an innocent individual's fundamental right to bodily integrity by injecting him with permanently mind-altering psychotropic drugs against his will solely because it believes there is a chance to medicate the individual into drug-induced "competence" for trial?

2. Whether the government's effort to forcibly medicate an innocent person, solely for the purpose of attempting to make him "competent" to stand trial, is reviewed under a strict scrutiny standard or under one of the lower standards, which standards are both recited in the conflicting lower court and appellate court decisions on this issue?

3. Whether the government should at least be required to prove, by clear and convincing evidence, each element of the strict scrutiny test before it violates an individual's right to be free from the forced injection of mind-altering medication?

4. Whether the district court must consider the effects of forcible medication on a defendant's Sixth Amendment trial rights before the government is allowed to permanently alter an individual's psychological chemistry?

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PETITION 1

I. The Petition Should Be Granted To Determine Whether The Government Can Violate An Innocent Individual's Fundamental Right To Bodily Integrity By Injecting Him With Permanently Mind-Altering Psychotropic Drugs Against His Will Solely Because It Believes That There Is A Chance To Medicate The Individual Into Drug-Induced "Competence" For Trial. 1

A. The petition should be granted because the right to bodily integrity is a fundamental right. 2

B. The government must establish a compelling or "extraordinary" interest in trying an individual for a non-violent crime in order to override his fundamental right. 7

C. Even absent a finding of a fundamental right, the forced medication of an accused solely for prosecutorial purposes violates minimum standards of due process. 11

II. The Petition Should Be Granted To Resolve The Widely Divergent Splits In Opinion Among Federal And State Courts Concerning The Standards To Be Applied When The Government Desires To Forcibly Medicate An Individual Solely For The Purpose Of Attempting To Make Him "Competent" To Stand Trial. 12

A. The petition should be granted to resolve a split in the lower federal courts and state courts regarding the proper standard of scrutiny. 12

B. The petition should be granted to resolve a split in the lower federal courts and state courts regarding the proper burden of proof. 15

C. The facts presented do not support medication of Dr. Sell under any standard or burden of proof. 17

III. The Petition Must Be Granted To Resolve The Split Of Authority Regarding Whether The Trial Court Must Consider The Effects The Medication Will Have On Dr. Sell's Trial Rights Before Medication Is Administered. 17

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OPINIONS BELOW

The court of appeals' opinion is reported at United States v. Sell, 282 F.3d 560 (8th Cir. 2002) and is reproduced in the appendix hereto at pages 1 through 12. The magistrate judge's opinion, which was not published, is reproduced in the appendix hereto at pages 13 through 28. The district court's opinion is not reported and is reproduced in the appendix hereto at pages 29 through 46. The court of appeals' denial of the petition for rehearing is provided herewith on page 47 of the appendix.

JURISDICTION

A divided panel of the court of appeals entered its judgment on March 7, 2002. By a vote of 5-4, the petition for rehearing and petition for rehearing en banc were denied on May 7, 2002. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Constitutional Provisions.

U.S. Const. amend. I:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech or of the press; or of the right of the people peaceably to assemble, and to petition the government for a redress of grievances.

U.S. Const. amend. V:

> No person shall be . . . deprived of life, liberty, or property, without due process of law.

U.S. Const. amend. VI:

> In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial . . . and to have the Assistance of Counsel for his defense.

U.S. Const. amend. IX:

> The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.

Statutory Provisions.

18 U.S.C. § 4241(d):

> (d) Determination and Disposition. - If . . . the court finds by a preponderance of the evidence that the defendant is presently suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his own defense, the court shall commit the defendant to the custody of the Attorney General. The Attorney General shall hospitalize the defendant for treatment in a suitable facility --
>
> > (1) for such a reasonable period of time, not to exceed four months, as is necessary to determine whether there is a substantial probability that in the foreseeable future he will attain the capacity to permit the trial to proceed; and
> >
> > (2) for an additional reasonable period of time until --

> > > (A) his mental condition is so improved that trial may proceed, if the court finds that there is a substantial probability that within such additional period of time he will attain the capacity to permit the trial to proceed; or
> > >
> > > (B) the pending charges against him are disposed of according to law;
> > >
> > > whichever is earlier.
>
> If, at the end of the time period specified, it is determined that the defendant's mental condition has not so improved as to permit the trial to proceed, the defendant is subject to the provisions of section 4246.

STATEMENT OF THE CASE

On May 7, 2002, in a five-to-four split vote, the United States Court of Appeals denied Dr. Charles Thomas Sell's ("Dr. Sell") petition for rehearing en banc. On March 7, 2002, two judges on the three-judge panel affirmed the District Court's opinion, over the vigorous dissent of the Honorable Judge Bye. The District Court opinion, issued on April 4, 2001, allowed the forcible medication of Dr. Sell solely based upon the government's desire to drug Dr. Sell into "competence" to stand trial. The District Court denied Dr. Sell's motion to reconsider the Magistrate Judge's August 9, 2000 Report and Recommendation, also condoning Dr. Sell's forced medication.

Dr. Sell is an intelligent, educated individual with advanced medical and dental training who opposes being involuntarily medicated with ineffective and potentially life-threatening medications. (Record on Appeal ("ROA") at 1099, 1108, 1137, 1120, 1121, 1136, 589, 617). At 53, Dr. Sell is a non-dangerous, unconvicted, pretrial detainee confined in the United States Medical Center for Federal Prisoners (the "Center") in Springfield, Missouri. (ROA at 1108). He has been held at the Center without treatment or trial for more than three and one half years, often under particularly difficult circumstances, and has been held in other facilities, including the Center, for more than four years without trial. (ROA at 551, 547, 559, 730-746, 1001-09). He is accused of insurance fraud.[1]

Prior to being indicted, Dr. Sell maintained a dental practice in St. Louis County, Missouri. (ROA 1108, 1099). He was married and has four children. (ROA at 1087, 1091, 1114). In addition, Dr. Sell served for almost two decades, with distinction, as an

[1]While there are other charges pending, the charges of insurance fraud were the sole basis for the Eighth Circuit's decision regarding involuntary medication. See Appendix at 7, n.8.

officer in the United States Army Dental Reserve, ultimately attaining the rank of Major. (ROA at 1085, 1142-59, 1161-74, 1177).

On July 30, 1997, after an undercover investigation involving government witnesses (with very questionable pasts and motives), Dr. Sell was indicted for Medicaid and insurance fraud for allegedly submitting false invoices to insurers for the purpose of obtaining payment for dental services that were not covered by the policies and program in violation of 18 U.S.C. § 1341, 42 U.S.C. § 1320a-7b(a)(1)(i), and 18 U.S.C. § 1957(a). (Cause No. 4:97CR00290-DJS). Dr. Sell denies the charges.

On October 14, 1998, after exploration of Dr. Sell's history of mental illness, counsel for Dr. Sell filed a notice of intent to introduce evidence of a mental disease or defect, which resulted in the Magistrate Judge ordering a psychological assessment of Dr. Sell. (ROA at 285-86, 293-317).

Ultimately, as a result of the psychological assessment, the District Court found Dr. Sell incompetent to stand trial because Dr. Sell "suffer[ed] from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him and to assist properly in his defense." (ROA at 341-43). Pursuant to 18 U.S.C. §4241(c), the court committed Dr. Sell to the custody of the United States Attorney General for a reasonable period of time "not to exceed four months." (ROA at 341). The Department of Justice then committed Dr. Sell to the custody of the Center, where he has been confined for over three and one half years, without treatment, often without a valid order of commitment. (See, e.g., ROA at 730-46, 1001-09, 551, 547, 559).

In 1999, only two weeks after Dr. Sell was committed, the Center sought to forcibly drug Dr. Sell with antipsychotic medications to restore him to competency for the sole purpose of bringing him to trial. (See, e.g., ROA at 347-50) (motion for appointed counsel to attend administrative proceeding). Dr. Sell opposes the medication because he has previously been treated with an antipsychotic drug and found the side effects to be intolerable. (ROA at 589, 617). In addition, because of his medical and dental training, Dr. Sell understands that antipsychotic medications are potent, mind-altering drugs with the potential for severe, irreversible side effects. (ROA at 556).

On April 4, 2001, two and one half years after Dr. Sell filed his notice of intent to introduce evidence of mental disease or defect, and after protracted delays in proceedings before the Magistrate Judge and the District Court, the District Court held that Dr. Sell was not dangerous, but that the Government's interest in restoring Dr. Sell to competency to stand trial was alone sufficient to warrant forcible medication. (April 4, 2001 Order at App. 37-46).

Dr. Sell appealed to the United States Court of Appeals for the Eighth Circuit and, on March 7, 2002, a divided Panel affirmed the decision of the District Court and held that, although not dangerous, Dr. Sell may be involuntarily medicated with antipsychotic drugs for the sole purpose of rendering him competent to stand trial. Dr. Sell's petition for rehearing by the Eighth Circuit en banc was denied 5-4.

REASONS FOR GRANTING THE PETITION

Dr. Sell remains an innocent man - he has never been convicted of any crime - and the government has wrongfully imprisoned him for over four years without a trial. Even though Dr. Sell poses no demonstrated risk of harm to himself or others, the government seeks to violate his First, Fifth, Sixth, and Ninth Amendment rights by injecting him with permanently mind-altering psychotropic drugs against his will. The government wants to medicate Dr. Sell into an artificially induced, drug-dependent competence so that the government can bring him to trial on charges involving alleged economic crimes of fraud and money laundering. If the Eighth Circuit Court of Appeals' decision is allowed to stand, a mentally incompetent individual will lose his right to refuse medication based solely on the government's unproven assertion that the individual is guilty of a non-violent crime.

The petition should be granted to determine whether an individual has a fundamental right to refuse the government's attempts to forcibly medicate him. Although this Court has ruled that the right to resist forced administration of psychotropic drugs is substantial, it has never considered whether this right is fundamental as a matter of substantive Constitutional law. This Court has repeatedly reiterated, however, that an individual has fundamental rights in the self-determination over one's body. Dr. Sell's interest in avoiding the permanent alteration of his brain chemistry and muscular control is as least as important as the rights previously recognized as fundamental.

In addition, the petition should be granted to ensure that the decision of the Eighth Circuit to narrow the fundamental liberty interest in self-determination of medical issues does not adversely affect or overrule, sub silentio, existing law relating to the control of

medical decisions about pregnant women and those opposing certain medical treatment on religious grounds.

The petition should also be granted to determine whether the government can violate a person's Constitutional rights for a purely prosecutorial motive. In the past, the Court has refused to allow the government to violate an individual's right to bodily integrity when its only motive was a prosecutorial one. In fact, the Constitution only sanctions intrusion upon the right to bodily integrity when the life or health of the individual or others is at risk. A citizen does not lose a fundamental, Constitutional right simply based on the fact that he is charged with a crime.

Importantly, unlike the Court's prior decisions regarding forcible medication, this case does not involve questions of prison administration or prison safety. Rather, this case presents the narrow question of whether an innocent individual loses his right to refuse psychiatric medication simply because the government has chosen to charge that individual with a crime. Constitutionally, the answer to this question must be no.

The petition should also be granted, and a decision by this Court is necessary, to resolve the divergent opinions in the lower federal courts and state courts regarding the standard of scrutiny and burden of proof to be applied to the government's efforts to forcibly medicate an individual solely for the purpose of making the individual competent to stand trial. About ten years ago, in Riggins v. Nevada, 504 U.S. 127 (1992), this Court specifically declined to prescribe the substantive standards concerning forced medication of a pretrial detainee, based on the insufficient record before it. Id. at 136. The Riggins Court also did not determine the government's burden of proof to establish that forcible

medication is proper. This case presents an opportunity to address the important Constitutional issues left open by Riggins.

In addressing the issues presented herein, this Court should also confirm a detainee's right to a Sixth Amendment pretrial inquiry to determine whether the forced medication would affect the detainee's jury trial rights.

APPENDIX

1. United States v. Sell, 282 F.3d 560 (8th Cir. 2002)

2. August 9, 2000 Memorandum and Order of United States Magistrate Judge

3. April 4, 2001 Order of United States District Court

4. May 7, 2002 Order Denying Petition for Rehearing and for Rehearing En Banc

United States Court of Appeals,
Eighth Circuit.

UNITED STATES of America, Appellee,
v.
Charles Thomas SELL, Appellant,
Association of American Physicians & Surgeons, Inc. Amicus on Behalf of Appellant.

No. 01-1862.

Submitted: Oct. 15, 2001.
Filed: March 7, 2002.
Rehearing and Rehearing En Banc Denied May 7, 2002. [FN*]

FN* Judges Loken, Murphy, Bye, and Riley would grant the petition for rehearing en banc. Judge McMillian took no part in the consideration of this case.

Defendant, a physician was indicted for health care fraud, attempted murder, conspiracy, and solicitation to commit violence. After a hearing, the United States District Court for the Eastern District of Missouri, Donald J. Stohr, J., reversed magistrate's finding that defendant posed danger to himself and others, but affirmed holding that forcible medication to restore defendant to competency was warranted. Defendant appealed. The Court of Appeals, Heaney, Circuit Judge, held that: (1) defendant did not pose a danger to himself or others; (2) as a matter of first impression, government could, subject to limitations, forcibly administer antipsychotic medication for sole purpose of rendering pre-trial detainee competent to stand trial; (3) government's interest in restoring defendant's competency so he could be brought to trial was paramount; (4) no less intrusive means of restoring defendant's competency were available; (5) antipsychotic medication was medically appropriate; and (6) district court properly considered defendant's Sixth Amendment right to a fair trial.

Affirmed.

Bye, Circuit Judge, filed dissenting opinion.

West Headnotes

[1] Mental Health ⇐432
257Ak432

Defendant, who was subject of hearing as to whether he was competent to stand trial, did not pose a danger to himself or others; defendant's inappropriate behavior in psychiatric facility amounted at most to an inappropriate familiarity and even infatuation with a nurse.

[2] Criminal Law ⇐1158(1)
110k1158(1)

Court of Appeals reviews district court's determination of questions of fact under the clearly erroneous standard.

[3] Mental Health ⇐436.1
257Ak436.1

Pre-trial detainee could, subject to limitations, be forcibly administered antipsychotic medication for sole purpose of rendering him competent to stand trial, even though detainee had a liberty interest, under Due Process Clause, in avoiding unwanted antipsychotic medication; charges against defendant were serious, such that government had essential state interest in bringing detainee to trial that sufficiently outweighed detainee's interest in refusing medication, no less intrusive means of restoring detainee's competency existed, and antipsychotic medication was medically appropriate for detainee's condition, in that medication could reasonably be expected to minimize detainee's delusions and render him competent to stand trial, and side-effects could be minimized. U.S.C.A. Const.Amend. 14.

[4] Mental Health ⇐436.1
257Ak436.1

In order to forcibly medicate an individual, for purpose of rendering him competent to stand trial, government must (1) present an essential state interest that outweighs the individual's interest in remaining free from medication, (2) prove that there is no less intrusive way of fulfilling its essential interest, and (3) prove by clear and convincing evidence that the medication is medically appropriate. U.S.C.A. Const.Amend. 14.

[5] Mental Health ⇐436.1
257Ak436.1

Medication is medically appropriate, for purpose of rendering a pre-trial detainee competent to stand trial, if (1) it is likely to render the patient competent, (2) the likelihood and gravity of side effects do not overwhelm its benefits, and (3) it is in the best

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medical interests of the patient.

[6] Criminal Law ⇐1139
110k1139

Question of whether district court erred by holding that government's interest in bringing detainee to trial was sufficient to outweigh detainee's interest in refusing medication presented a mixed question of law and fact, such that Court of Appeals reviewed district court's finding de novo.

[7] Mental Health ⇐436.1
257Ak436.1

Government has an essential interest in bringing a defendant to trial, but not all charges are sufficient to justify forcible medication of a defendant; rather, charges must be serious.

[8] Mental Health ⇐436.1
257Ak436.1

For purpose of justifying forcible medication so as to render detainee competent to stand trial, despite his liberty interest in refusing antipsychotic medication, 62 charges of fraud and one charge of money-laundering were sufficiently serious to constitute a paramount government interest. U.S.C.A. Const.Amend. 14.

[9] Mental Health ⇐436.1
257Ak436.1

No less intrusive means existed by which government could achieve its essential interest in rendering detainee competent to stand trial, as required for forcible medication of detainee with antipsychotic medication; two treating physicians testified that medication was most effective treatment for delusional disorder, and the only way detainee would be restored to competency.

[10] Mental Health ⇐432
257Ak432

The government may not constitutionally bring an incompetent defendant to trial.

[11] Mental Health ⇐436.1
257Ak436.1

Antipsychotic medication was medically appropriate for pre-trial detainee who was incompetent to stand trial; medication could reasonably be expected to minimize detainee's delusions and render him competent for trial, side-effects of medication could be minimized, and medication was in detainee's medical interest, in that his delusions interfered with his ability to make sound judgments about his life and his treatment, and his disorder impaired his interpretation of reality and his reasoning.

[12] Mental Health ⇐436.1
257Ak436.1

District court properly considered defendant's Sixth Amendment right to a fair trial when it ordered forcible administration of antipsychotic medication, where court determined that defendant would be able to participate meaningfully in his trial while under influence of the medication, and that medication would enable defendant to communicate with his counsel in a rational manner, and court indicated willingness to reexamine Sixth Amendment claim after medication regimen had begun, when effects of medication on defendant's competency and demeanor could properly be evaluated. U.S.C.A. Const.Amend. 6.

***562** Lee T. Lawless, St. Louis, Missouri, argued, for appellant.

Dorothy L. McMurtry, Assistant U.S. Attorney, St. Louis, Missouri, argued (Raymond W. Gruender and Howard J. Marcus, on the brief), for appellee.

Before BOWMAN, HEANEY and BYE, Circuit Judges.

HEANEY, Circuit Judge.

Appellant Dr. Charles Sell, D.D.S. is charged with health care fraud, attempted murder, conspiracy, and solicitation to commit violence. In this appeal, Sell challenges the district court's [FN1] determination that he may be involuntarily medicated with antipsychotic drugs for the sole purpose of rendering him competent for trial. We affirm.

FN1. The Honorable Donald J. Stohr, United States District Court for the Eastern District of Missouri.

I. Background

On May 16, 1997, Sell was charged in a federal criminal complaint with making false representations in connection with payments for health care services

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in violation of 18 U.S.C. § 1035(a)(2). The government alleged that Sell and his wife submitted false claims to Medicaid and private insurance companies for dental services not provided, including false documentation and bogus x-rays in support of these claims. On May 20, 1997, the government filed a motion for psychiatric examination of Sell to determine his competence to stand trial. [FN2] On May 20, 1997, a magistrate judge ordered that Sell be sent to the U.S. Medical Center for Federal Prisoners at Springfield, Missouri ("Springfield") for an evaluation. On July 15, 1997, after receiving a psychiatric evaluation from Springfield, the district court held that Sell was competent to stand trial. The report, which was accepted without objection, stated that Sell was currently competent to stand trial but that there was a possibility that he would develop a psychotic ***563** episode in the future. On July 30, 1997, an indictment was returned against Sell and his wife, charging them with fifty-six counts of mail fraud, six counts of medicaid fraud, and one count of money-laundering.

FN2. Sell has a history of mental illness.

In August 1997, Sell was released on bond. On January 22, 1998, the government filed a bond revocation petition alleging that Sell had violated the conditions of his release by attempting to intimidate a witness. A warrant was issued for Sell's arrest and he was brought before a magistrate judge for an initial appearance. Sell's behavior at this appearance was out of control. He screamed, shouted, and used racial epithets. Nonetheless, the judge tried to proceed, but when she advised Sell of his rights, he leaned towards her and spit directly in her face.

On January 26, 1998, a bond revocation hearing was held, and shortly thereafter, the court ordered that Sell's bond be revoked and that he be detained. At this hearing, the court received evidence that Sell's mental condition was deteriorating. Sell was not sleeping at night because he expected the FBI to barge into his house. A psychiatrist reported that Sell soon could become a danger to himself and others.

On April 23, 1998, Sell was charged in a second indictment with conspiring and attempting to kill a witness and an FBI agent. The government contends that Sell and his wife asked a hit man to plot the murder of a former employee at his dental office who planned to testify against him on the fraud charges. The government also alleges that Sell plotted to kill the African-American FBI agent who had arrested him. The two indictments were joined.

During the next several months, the trial date was continued on a number of occasions at the request of both parties. On February 9, 1999, Sell's counsel filed a motion asking this court to hold a hearing to determine Sell's competency. The government filed a separate motion to have a government psychologist examine Sell. Both Sell's psychologist and the government psychologist diagnosed Sell with delusional disorder, persecutory type. [FN3]

FN3. Delusional disorder is characterized by the presence of one or more non-bizarre delusions that persist for at least one month. *Diagnostic and Statistical Manual of Mental Disorders IV* at 296. The delusions are generally plausible ideas that can conceivably occur in real life. *Id.* The persecutory subtype of delusional disorder is characterized by a person's belief that he is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long term goals. *Id.* at 298.

On April 14, 1999, the district court held a hearing on Sell's competency. Upon consideration of the evidence, the court found that Sell was suffering from a mental disease or defect rendering him incompetent to assist properly in his defense, and thus incompetent to stand trial. The court ordered that Sell be hospitalized at Springfield for a reasonable period of time not to exceed four months to determine whether there was a substantial probability that Sell would attain the capacity to stand trial.

At Springfield, Sell was under the care of two clinicians, Dr. DeMier, the clinical psychiatrist, and Dr. Wolfson, the consulting psychiatrist. Both Dr. DeMier and Dr. Wolfson determined that Sell was in need of antipsychotic medication. [FN4] On ***564** June 9, 1999, an administrative hearing was held before a medical hearing officer. Dr. DeMier and Dr. Wolfson testified in favor of using antipsychotic medication in the treatment of Sell, and testified that it was the only way he could be restored to competency. Sell proffered the affidavit of his psychiatrist, Dr. Cloninger, who asserted that he did not think Sell would respond well to medication. Cloninger Aff. ¶¶ 8, 17. Sell also called a number of witnesses and testified that he did not want to take antipsychotic medication and have his chemistry

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altered. The medical hearing officer concluded that antipsychotic medication was the treatment of choice. This finding was based on the fact that his delusional thinking could make him dangerous and that no other drug could treat his delusional symptoms. Dr. Sell filed an administrative appeal that was denied. The Medical Center delayed the administration of the medication to give Sell the opportunity to seek review by the district court.

FN4. Justice Kennedy described antipsychotic medications in his concurring opinion in *Riggins v. Nevada*:

First introduced in the 1950's, antipsychotic drugs ... have wide acceptance in the psychiatric community as an effective treatment for psychotic thought disorders. *See American Psychiatric Press Textbook of Psychiatry* 770-774 (J. Talbott, R. Hales, & S. Yodofsky eds. 1988 (*Textbook of Psychiatry*)); Brief for American Psychiatric Association as Amicus Curiae 6-7. The medications restore normal thought processes by clearing hallucinations and delusions. *Textbook of Psychiatry* at 744.

Riggins v. Nevada, 504 U.S. 127, 141, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) (Kennedy, J., concurring). In *Washington v. Harper*, the Supreme Court discussed the side effects associated with antipsychotic medications:

The purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes. (Citation omitted). While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects. One such side effect identified by the trial court is acute dystonia, a severe involuntary spasm of the upper body, tongue, throat, or eyes. The trial court found that it may be treated and reversed within a few minutes through use of the medication Cogentin. Other side effects include akathesia (motor restlessness, often characterized by an inability to sit still); neuroleptic malignant syndrome (a relatively rare condition which can lead to death from cardiac dysfunction); and tardive dyskinesia, perhaps the most discussed side effect of antipsychotic drugs. See Finding of Fact 9, App. to Pet. for Cert. B-7; Brief for American Psychological Association as Amicus Curiae 6-9. Tardive dyskinesia is a neurological disorder, irreversible in some cases, that is characterized by involuntary, uncontrollable movements of various muscles, especially around the face. See *Mills*, 457 U.S., at 293, n. 1, 102 S.Ct., at 2445, n. 1. The State, respondent, and amici sharply disagree about the frequency with which tardive dyskinesia occurs, its severity, and the medical profession's ability to treat, arrest, or reverse the condition. A fair reading of the evidence, however, suggests that the proportion of patients treated with antipsychotic drugs who exhibit the symptoms of tardive dyskinesia ranges from 10% to 25%. According to the American Psychiatric Association, studies of the condition indicate that 60% of tardive dyskinesia is mild or minimal in effect, and about 10% may be characterized as severe. Brief for American Psychiatric Association et al. as Amici Curiae 14-16, and n. 12; see also Brief for American Psychological Association as Amicus Curiae 8.

Washington v. Harper, 494 U.S. 210, 229-30, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990).

On September 29, 1999, a United States Magistrate Judge conducted a full judicial hearing. At that hearing, the Government called two witnesses, Dr. DeMier and Dr. Wolfson. They testified that Sell was in need of antipsychotic medication, that his condition would continue to deteriorate without it, that his behavior could be dangerous, and that antipsychotic medication was likely to restore him to competency. On August 9, 2000, the magistrate entered an order finding that Sell posed a danger to himself and others. *United States v. Sell*, No. 4: 98CR177, (E.D.Mo. Aug. 9, 2000) (order granting government's motion to involuntarily medicate defendant). Based on this finding, the magistrate authorized ***565** the government to forcibly medicate Sell with antipsychotic medication.

In April 2001, the district court reversed the magistrate's finding that Sell posed a danger to himself and others, noting that the evidence in the record was insufficient to support such a finding. Despite this reversal, the district court affirmed the magistrate's order, holding that the Government's interest in restoring Sell to competency so that he can stand trial was alone sufficient to warrant forcible medication.

Sell appeals this decision and asks this court to decide whether the district court erred in holding that he could be forcibly injected with antipsychotic drugs for the sole purpose of restoring his competency to stand trial. Sell also asks us to examine whether: (1)

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the district court applied the correct standard of review; (2) whether the district court properly considered his Sixth Amendment right to a fair trial, and (3) whether the government has proven by clear and convincing evidence that the medication is medically appropriate and that the medication has a reasonable probability of restoring his competency. The Government argues that the district court did not err on these grounds. It further argues that the district court's finding that Sell was not dangerous was erroneous and that Sell's dangerousness provides an alternate ground for affirmance in this case.

II. Discussion

A. Sell's Dangerousness to Himself and Others.

[1][2] First, we consider the government's claim that the district court erred in overturning the magistrate's determination that Sell is dangerous. We review the district court's determination of questions of fact under the clearly erroneous standard. *See United States v. Kissinger*, 986 F.2d 1244, 1246 (8th Cir.1993). The government argues that the district court did not give adequate weight to Sell's *potential* to be a danger to himself or others. The district court noted, however, that Sell's inappropriate behavior at Springfield amounted at most to an "inappropriate familiarity and even infatuation" with a nurse. Upon review, we agree that the evidence does not support a finding that Sell posed a danger to himself or others at the Medical Center. The district court properly reversed the magistrate's finding.

B. Forcible Administration of Antipsychotic Drugs to Restore Competency

Next, we consider the question of whether the district court erred in holding that a pretrial detainee may be forcibly injected with antipsychotic medication for the sole purpose of rendering him competent to stand trial. This is an issue of first impression for this court. *Cf. Papantony v. Hedrick*, 215 F.3d 863, 865 (8th Cir.2000) (holding that in the context of a *Bivens* action, there is no clearly established right of a pre-trial detainee not to be forcibly administered antipsychotic drugs for the sole purpose of rendering him competent for trial). In *Washington v. Harper*, the Supreme Court recognized that individuals possess "a significant liberty interest in avoiding unwanted administration of antipsychotic drugs." 494 U.S. 210, 221, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990); *cf. United States v. Weston*, 255 F.3d 873, 876 (D.C.Cir.2001) (citations omitted) ("The due process liberty interest in avoiding unwanted antipsychotic medication may be 'significant,' but it is not absolute."). In *Harper*, a convicted prison inmate claimed that the State of Washington violated his due process rights by administering antipsychotic drugs against his will. 494 U.S. at 217, 110 S.Ct. 1028. The Court acknowledged that Harper had a liberty interest ***566** in avoiding unwanted medication but held that the "Due Process Clause permits the state to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if [the inmate] is dangerous to himself or others and the treatment is in [the inmate's] medical interest." *Id.* at 211, 110 S.Ct. 1028.

In *Riggins v. Nevada*, the Court applied its *Harper* analysis to the issue of whether a pre-trial detainee may be forcibly injected with antipsychotic medication for the purpose of rendering him competent for trial. 504 U.S. 127, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992). In *Riggins*, a pre-trial detainee was forcibly administered the antipsychotic drug Mellaril after a Nevada district court denied the detainee's pre-trial motion to terminate the medication with a one-page order that gave no indication as to the court's rationale. *See id.* at 130-31, 112 S.Ct. 1810. A jury convicted Riggins, [FN5] and he appealed, arguing that the forced administration of Mellaril denied him the ability to assist in his own defense and prejudicially affected his attitude, appearance and demeanor at trial. *See id.* at 131, 112 S.Ct. 1810. Riggins further argued that the prejudice was not justified because the state did not demonstrate a need to administer the drug, nor did it explore alternative treatments. The Supreme Court agreed, and held that Riggins's Fourteenth Amendment rights had been violated because the Nevada court did not acknowledge the detainee's liberty interest in freedom from unwanted medication, make any findings on the need for forced medication, and make findings on reasonable alternatives to antipsychotic medication. *See id.* at 136-37, 112 S.Ct. 1810. The Court also noted that forcible administration of antipsychotic drugs may have interfered with Riggins's Sixth Amendment right to a fair trial. *See id.* The Court, therefore, reversed and remanded the case.

FN5. At trial, Riggins unsuccessfully presented an insanity defense and was convicted of murder and sentenced to death.

The Supreme Court did not have the opportunity to determine when involuntary medication could be used on a pre-trial detainee because the Nevada court

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offered the accused almost no protection against involuntary medication. The Supreme Court did note, however, that:

> Under *Harper*, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness. The Fourteenth Amendment guarantees at least as much protection to persons the state detains for trial. (Citation omitted).
>
> ... Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the district court had found, that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others. (Citation omitted). Similarly, the state might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means.

Id. at 135, 112 S.Ct. 1810.

Based on this language, we conclude that subject to the limitations outlined below, the government may forcibly administer antipsychotic medication for the sole purpose of rendering a pre-trial detainee competent to stand trial without violating the accused's due process rights.

***567** C. The Standard of Review for Forcible Administration of Antipsychotic Drugs.

[3][4][5] We now consider Sell's claim that the district court employed the wrong standard of review to determine whether forced administration of medication is appropriate in this case. Sell encourages us to adopt strict scrutiny, but the Supreme Court declined to adopt such a standard in *Riggins*. *See Riggins*, 504 U.S. at 136, 112 S.Ct. 1810. [FN6] Based on the Supreme Court's decisions in *Riggins* and *Harper*, and the decisions of our sister courts, [FN7] we hold that the government must meet the following test in order for the government to forcibly medicate an individual. First, the government must present an essential state interest that outweighs the individual's interest in remaining free from medication. *See Riggins*, 504 U.S. at 135, 112 S.Ct. 1810 (noting that the government must prove an overriding state interest). Second, the government must prove that there is no less intrusive way of fulfilling its essential interest. *See id.* Third, the government must prove by clear and convincing evidence that the medication is medically appropriate. *See id.* Medication is medically appropriate if: (1) it is likely to render the patient competent, *see Weston*, 255 F.3d at 876; (2) the likelihood and gravity of side effects do not overwhelm its benefits, *see id.*; and (3) it is in the best medical interests of the patient. *See Harper*, 494 U.S. at 227, 110 S.Ct. 1028 (noting that the court should consider the petitioner's medical interest). The district court did not explicitly apply this test, so ***568** we review the district court in light of the standards we have set forth.

> FN6. The court stated: "We have no occasion to finally prescribe such substantive standards ... since the District Court allowed administration of Mellaril to continue without making any findings about reasonable alternatives." *Riggins*, 504 U.S. at 136, 112 S.Ct. 1810.
>
> FN7. Other courts have come to contradictory conclusions on what substantive standards are necessary to satisfy a pretrial detainee's due process rights. The Sixth Circuit held that courts must apply the strict scrutiny standard when the state wishes to forcibly medicate a non-dangerous pre-trial detainee. *See United States v. Brandon*, 158 F.3d 947, 960 (6th Cir.1998). The D.C. Circuit interpreted *Riggins* to require "heightened scrutiny" that takes into consideration the severity of infringement that antipsychotic drugs impose on an individual's liberty interest, the need to find an essential state policy that provides an overriding justification for forced medication, and a requirement to consider less intrusive alternatives. *See United States v. Weston*, 255 F.3d 873, 880 (D.C.Cir.2001). Similarly, the Southern District of California refused to adopt a strict scrutiny standard. Rather, it stated that the government must meet the following standard:
>
> First, the government must demonstrate that "administration of anti- psychotic drugs is necessary to accomplish an essential state policy." (Citation omitted). Second, the government must show that "there is a sound medical basis for treatment with anti-psychotic medication." (Citation omitted). In making this showing, the government may provide "medical testimony regarding [Defendant's] mental illness and its symptoms as well as the effects that anti-psychotic medication will have, both beneficial and harmful, on [Defendant's] physical and mental health." Third, and most importantly, the government must establish "that there is no significant risk that the medication will alter in any material way the defendant's capacity or willingness to react to testimony at trial or assist counsel." (Citation omitted). [T]he government must establish these elements by clear and convincing evidence.
>
> *United States v. Sanchez-Hurtado*, 90 F.Supp.2d 1049, 1055 (S.D.Cal.1999). Like our sister courts, we believe that we must apply some sort of heightened standard of review, but unlike the Sixth Circuit, we do not adopt the strict scrutiny standard. *See e.g. Weston*, 255 F.3d at 888 (noting that the Supreme Court denied adopting a strict scrutiny test in *Riggins* but also appeared not to apply a reasonableness test or its various analogues: arbitrary and capricious, rational basis or exercise of professional judgment).

[6] The first question, therefore, is whether the district court erred by holding that the government's interest in bringing Sell to trial is sufficient to outweigh Sell's interest in refusing medication. This is a mixed question of law and fact, so we review the district court's finding de novo. *See Boysiewick v. Schriro*, 179 F.3d 616, 619 (8th Cir.1999). To make this determination, we must weigh the government's interest in rendering Sell competent against Sell's interest in refusing unwanted medication.

[7][8] The government has an essential interest in bringing a defendant to trial. *See Illinois v. Allen*, 397 U.S. 337, 347, 90 S.Ct. 1057, 25 L.Ed.2d 353 (1970) (Brennan, J., concurring) ("Constitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and a prerequisite to social justice and peace."). Not all charges, however, are sufficient to justify forcible medication of a defendant; rather, the charges must be serious. *See United States v. Brandon*, 158 F.3d 947, 961 (6th Cir.1998). Here, the sixty-two charges of fraud and the single charge of money-laundering are serious, a fact not denied by the defendant. [FN8] Despite Sell's significant liberty interest in refusing antipsychotic medication, in view of the seriousness of the charges, we believe that the government's interest in restoring his competency so that he may be brought to trial is paramount. [FN9]

> FN8. Although Sell is also charged with conspiring to murder an FBI officer and a witness, we base our reasoning solely on the seriousness of the fraud charges. It is possible that Sell's threats after his first indictment were a manifestation of his delusional disorder and we decline to make a determination about whether those charges suffice to involuntarily medicate him.
>
> FN9. We note that the government's interest in preserving a scheme of ordered liberty can only be achieved if a defendant is competent at trial. If the medication does not render Sell competent, his trial cannot proceed. *See infra* Part II.D.

[9][10] The second part of our analysis is whether the district court erred in finding that there were no less intrusive means by which the government may achieve its essential interest. *See Riggins*, 504 U.S. at 135, 112 S.Ct. 1810 (noting that the government must prove that there is no less intrusive means). The government may not constitutionally bring an incompetent defendant to trial, *see Pate v. Robinson*, 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed.2d 815 (1966), so the only way the government may try Sell is by restoring his competency. Both Dr. Wolfson and Dr. DeMier testified that antipsychotic medication is the most effective treatment for delusional disorder and that it is the only way Sell could be restored to competency. *See* Transcript of Evidentiary Hr'g, Sept. 29, 1999 at 21, 75-78. Even Dr. Cloninger, who submitted an affidavit on behalf of Sell and stated that antipsychotic drugs are not a proven treatment, did not suggest any alternative means of restoring competency. *See generally* Cloninger Aff. Based on this evidence, we believe that the district court correctly concluded that there were no less intrusive means.

Third, we must determine whether the evidence supports the district court's conclusion that antipsychotic medication is medically appropriate for Sell's treatment. We review the district court's findings of fact under the clearly erroneous standard. *See Love v. M.D. Reed*, 216 F.3d 682, 687 (8th Cir.2000). Whether a proposed action is medically appropriate depends on the judgment of medical professionals. *See *569 Harper*, 494 U.S. at 231, 233-34, 110 S.Ct. 1028. At the hearing before the Magistrate Judge, the government presented testimony from Dr. DeMier and Dr. Wolfson. Dr. DeMier, Sell's treating psychologist, testified that antipsychotic medication is the only treatment that has been shown to be effective in treating delusional disorder and it is the only treatment that could restore Sell to competency. He also stated that he has treated two patients suffering from delusional disorder with antipsychotic medication. Of the two, one was

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restored to clinical competency; the other patient improved, but did not regain competency. [FN10] Dr. DeMier also stated that antipsychotic medications have "potentially significant side effects, but there's also potentially, very significant recovery from symptoms."

FN10. The patient who was successfully treated was given Haldol, a typical antipsychotic drug. The patient who was not restored to competency received Olanzapine, an atypical antipsychotic drug.

Dr. Wolfson, the staff psychiatrist who works as a consultant on Sell's case, also recommended that Sell be treated with antipsychotic drugs. Dr. Wolfson has treated seven patients with delusional disorder but only four for the purpose of restoring competency. [FN11] Dr. Wolfson reported that all seven benefitted clinically from antipsychotic medication and of the four who were treated for restoration of competency, three regained competency. Dr. Wolfson testified that the medical literature indicated that patients with delusional disorder respond less to medication than patients with other illnesses, but he stated that he doubts the accuracy of that conclusion and noted that the literature shows favorable results in many cases. [FN12] Dr. Wolfson admitted that there are both harmful and unpleasant side effects to antipsychotic drugs; these include sedation, neuroleptic malignant syndrome, which is rare but fatal, [FN13] and tardive dyskinesia and/or dystonic reaction, which causes a person to have involuntary movements of various parts of the body. Dr. Wolfson also stated, however, that the existence and/or degree of side effects could be controlled by changes in the doses and type of medication being used. He testified that the new generation of atypical antipsychotic drugs, such as Pimozide, have more benign side effects than the older typical antipsychotic drugs, such as Haldol. Dr. Wolfson admitted, however, that the atypical drugs can only be administered orally, and therefore cannot be used to forcibly drug uncooperative patients.

FN11. He treated one of the patients twice. This patient was restored to competency, relapsed, then restored a second time.

FN12. Dr. Wolfson explained that:

First, the delusions stop expanding.... It's even conceivable that some delusional material may regress.... [O]ur first goal [is] to diminish the impact on ... actions and ... judgment of the illness. Second, [is] to minimize the expansion of the delusional system.... [I]t's typically been my experience [that this is] accomplished with other patients.

Transcript of Evidentiary Hr'g, Sept. 29, 1999 at 137.

FN13. Dr. Wolfson testified that the incidence of this side-effect is one in ten thousand cases.

To combat this testimony, Sell presented the affidavit of Dr. Cloninger. Dr. Cloninger stated that "there is no evidence that [antipsychotic medications] are beneficial for patients with Delusional Disorder." Cloninger Aff. at 8. Dr. Cloninger admitted that antipsychotic drugs are often beneficial in treating schizophrenia but maintained that they do not provide the same benefit in the treatment of delusional disorder. Dr. Cloninger attached to his affidavit an excerpt from the American Psychiatric ***570** Press Textbook of Psychiatry. That text notes that there is a disagreement between experts on the effectiveness of treating delusional disorders with antipsychotic medication, but it also states that the medication may be useful, particularly for accompanying anxiety, agitation, and psychosis. Donald W. Black et al., *Schizophrenia, Schizophreniform Disorder, and Delusional (Paranoid) Disorders*, in *Textbook of Psychiatry* (John A. Talbott et al. eds.) 1988. Dr. Cloninger was not able to recommend a less intrusive alternative to restore Sell to competency; rather, he suggested that treatment be limited to basic support and voluntary symptomatic treatment, and that such treatment also include access to exercise and reading material. *See* Cloninger Aff. ¶¶ 18-19.

In addition, Sell also presented the court with a report from the Federal Bureau of Prisons Institutional Metropolitan Correctional Center ("MCC") in which Dr. Daniel Greenstein, the forensic psychologist at MCC, stated that delusional disorders do not typically respond to medication or psychotherapy.

Based on the totality of this evidence, Sell argues that the district court was clearly erroneous in finding that antipsychotic medication was medically appropriate. He contends that the district court erred by basing its finding, in part, on testimony that atypical antipsychotic medications have more benign side effects, because atypical drugs can only be administered orally, thus they cannot be given involuntarily. Sell also argues that the government did not prove that the medication has a reasonable

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probability of restoring competency. Finally, Sell argues that the court erred in finding medical appropriateness when the government failed to disclose which medication it would use. [FN14] Sell posits that without knowing which drugs would be administered, he was incapable of making anything more than a generalized argument. *See United States v. Sell*, No. 4: 98CR177 at 7 (April 4, 2001) (upholding Magistrate's order allowing the involuntarily medication of Sell and stating that Sell's arguments against medication were generalized).

FN14. Dr. Wolfson stated that he did not want to be pinned down to a single drug because he hoped to leave part of the choice up to Sell. He recommended that the drugs Quetiapine or Olanzapine be used.

[11] We disagree with these assertions. We acknowledge that there is a difference of opinion on the efficacy of using antipsychotic drugs to treat delusional disorder, but we do not believe that the district court committed clear error in finding that the government proved medical appropriateness by clear and convincing evidence. First, the government presented evidence that the medication can reasonably be expected to minimize Sell's delusions and render him competent for trial. Dr. DeMier has a 50% success rate and Dr. Wolfson has a 75 % success rate in restoring competency to patients with delusional disorders. Moreover, the medication improved the condition of all the patients they treated, whether or not they were restored to competency. Dr. Wolfson testified about how the medication works, stating that the medication should reduce the impact of the delusion on Sell's thought process. Although we cannot say with 100% certainty whether Sell will regain competency with his treatment, the district court did not clearly err in finding a sufficient likelihood that antipsychotic medication will restore Sell's competence.

Second, the government proved that the side-effects produced by the medication could be minimized through careful treatment and changing medications and dosages. ***571** Although Dr. Wolfson did not name a specific medication, he did name the two he would most likely use. Therefore, we reject Sell's contention that he was not given the opportunity to make specific objections to specific drugs. Furthermore, we reject Sell's argument that the court erred in basing its opinion in part on the availability of atypical antipsychotic drugs which can only be administered orally. The availability of the atypical medications was not determinative to the district court's findings, and the evidence supports the conclusion that the doctors treating Sell will be able to reduce the incidence of unpleasant and harmful side-effects produced by typical antipsychotic medication as well.

Finally, the district court appropriately considered Sell's medical interest. The court noted that Sell's delusions interfere with his ability to make sound judgments about his life and his treatment, and that his disorder currently impairs and misleads his interpretation of reality and his reasoning. The government presented evidence that antipsychotic medication is commonly used to help reduce delusions and their impact on an individual's life, and the court found that these benefits outweighed the risks associated with antipsychotic drugs.

The district court did not err in applying the wrong standard of review. As required, the court found that the government has an essential interest in adjudicating the serious charges against Sell. The court found that involuntary medication is the only way for the government to achieve its interest in fairly trying Sell and found that the medication is medically appropriate for him. The government proved these elements by clear and convincing evidence. Therefore, we find no reversible error in the standard of review employed by the district court.

We note, however, that this is a limited holding. We do not believe this standard will be met in all circumstances in which the government wishes to restore competence. Furthermore, we note that an entirely different case is presented when the government wishes to medicate a prisoner in order to render him competent for execution. *See, e.g., Singleton v. Norris*, 267 F.3d 859 (8th Cir.2001), *vacated and reh'g en banc granted* (Dec. 5, 2001). Therefore, our holding must be read narrowly.

D. Sell's Sixth Amendment Rights

[12] Finally, we consider whether the district court properly considered Sell's Sixth Amendment right to a fair trial when it ordered the forcible medication. The district court held that Sell's Sixth Amendment claim was premature because the effects of the medication on his competency to assist counsel and on his demeanor could properly be considered after medication. We note that before forcibly medicating an accused, there must be evidence that he will be able to participate in a fair trial. *See Brandon*, 158

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F.3d at 960. That burden was met in this case. First, the magistrate found that the evidence indicated that Sell would be able to participate meaningfully in his trial while he is under the influence of the medication. *See United States v. Sell*, 4:98CR177 at 13 (E.D.Mo. Aug. 9, 2000). Also, the magistrate found that the medication would allow him to communicate with his counsel in a rational manner. *See id.* The magistrate further noted that Dr. Wolfson intends to use drugs with a low side-effect profile, to change drugs and dosages based on the side-effects Sell experiences, and above all, to avoid sedation. *See id.* The district court affirmed these findings. *See generally United States v. Sell*, 4:98CR177 at 5-9 (E.D.Mo. Apr. 4, 2001).

***572** We find that the medical evidence presented indicated a reasonable probability that Sell will fairly be able to participate in his trial. As a result, we believe that the effects of the medication on Sell's competency and demeanor may properly be considered once the medication is administered. The district court noted its willingness to re-examine Sell's Sixth Amendment claim after the medication regimen has begun. *See id.* at 15. The evidence offered, that the drugs should not interfere with Sell's right to a fair trial, as well as post-medication procedures that ensure he will not be tried unfairly, are sufficient to protect Sell. There is no reversible error.

III. Conclusion

Having found no reversible errors, we affirm the district court's determination that Sell may be involuntarily medicated for the purpose of rendering him competent to stand trial.

BYE, Circuit Judge, dissenting.

Unlike the majority, I would apply the strict scrutiny standard of review for the reasons enunciated by the Sixth Circuit in *United States v. Brandon*, 158 F.3d 947, 956-61 (6th Cir.1998). But even under the majority's three-part test, the charges against Dr. Sell are not sufficiently serious to forcibly inject him with antipsychotic drugs on the chance it will make him competent to stand trial. I therefore respectfully dissent.

The first part of the majority's test requires the government to demonstrate an essential interest that outweighs his interest in remaining free from medication. *Ante* at 567. The majority perfunctorily concludes the government's interest in prosecuting the defendant for sixty-two counts of fraud and one count of money laundering qualifies as an essential interest that trumps Dr. Sell's significant liberty interest in refusing antipsychotic medication. I strongly disagree.

While the government possesses an interest in bringing a defendant to trial, *ante* at 568, I do not believe every charge is sufficient to justify forcible medication of a defendant. *See Riggins v. Nevada*, 504 U.S. 127, 135, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) (stating the government *might* be able to medicate a defendant involuntarily if "it could not obtain an adjudication of [his] guilt or innocence by using less intrusive means") (emphasis added). It is helpful to compare two recent decisions confronting this precise issue. In *United States v. Weston*, 255 F.3d 873 (D.C.Cir.2001), the Court of Appeals for the District of Columbia recognized the government's interest in adjudicating those who violate the law. In that case, Russell Weston entered the Capitol building and shot three police officers, killing two of them. A grand jury indicted Weston on two counts of *murder*, and one count of *attempted murder* of a federal law officer, in addition to three counts of *using a firearm in a crime of violence*. *Weston* explained that "[t]he government's interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business." 255 F.3d at 881. *Weston* also noted "[t]he statutory sentences for the crimes Weston is accused of committing--*life in prison and death*--reflect the intensity of the government's interest in bringing those suspected of such crimes to trial." *Id.* (emphasis added).

Weston typifies the case where the government's interest is paramount because the charges include the most serious crimes known to man. Few cases involve crimes as serious as those in *Weston*, however. ***573** In *Brandon*, the Sixth Circuit noted the government's reduced interest in trying a defendant accused of lesser crimes. 158 F.3d at 947. Ralph Brandon was charged with sending a threatening communication through the mail. The Sixth Circuit stated "[w]e find it difficult to imagine ... that the government's interest in prosecuting the charge of sending a threatening letter through the mail could be considered a compelling justification to forcibly medicate Brandon." *Id.* at 961; *cf. Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir.1984) (questioning whether the state's interest in trying suspects could ever outweigh a criminal defendant's

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interest in avoiding forcible medication with antipsychotic drugs). *Brandon* also noted the maximum penalty the defendant faced for sending a threatening communication--five years imprisonment. 158 F.3d at 961.

Weston and *Brandon* teach us that the forcible administration of antipsychotic medication may be warranted when the government seeks to prosecute incontestably serious crimes, but not when it seeks to prosecute crimes less so. Cases involving crimes of intermediate severity may present vexing questions, but Dr. Sell's case poses no such challenge. The crimes with which he has been charged are comparable to those in *Brandon* and thoroughly distinct from those in *Weston*. Dr. Sell is charged with making false representations in connection with the payment of health care services, 18 U.S.C. § 1035(a)(2), and money laundering, 18 U.S.C. § 1957(a). The maximum penalty for these charges is five and ten years imprisonment, respectively. He cannot be put to death nor imprisoned for life if convicted of these crimes, as was the case in *Weston*. He is charged with crimes which are far less serious than the violent, heinous and deadly crimes with which Weston was charged. Indeed, they are nonviolent and purely economic. There is no identifiable victim for these types of crimes; rather, only society's interest is harmed.

The majority deems the charges serious in part because of the number of counts Dr. Sell faces (63). At first blush, the sixty-two counts of fraud and the single count of money laundering might appear to make the charges seem more serious, but the sheer number is an inaccurate yardstick for measuring the severity of his alleged offenses. He will be sentenced under the United States Sentencing Guidelines, which direct his sentence to be determined by the total dollar value of the fraud, *not* the number of counts. *See* U.S. Sentencing Guidelines Manual (U.S.S.G.) ch. 3 pt. D & §§ 5G1.2, 2B1.1, 2S1.1 (2001). An overly generous estimation of Dr. Sell's alleged illegal activity would place the value of his fraud within the range of $400,000 to $1,000,000. Applying this estimate, his base offense level would be 20 and (assuming he has no prior criminal history) his sentencing range would be 33-41 months. *See* U.S.S.G. § 2B1.1. This sentencing range demonstrates the charges against him are not serious enough to justify forcible medication. *Ante* at 568 ("Not all charges, however, are sufficient to justify forcible medication of a defendant; rather, the charges must be serious"). In any event--setting aside the Guideline estimations altogether--Dr. Sell's potential sentence is far more proportional to the maximum five year sentence in *Brandon* than to the maximum life-in-prison and death sentences in *Weston*.

The majority states Dr. Sell does not deny the severity of the fraud and money laundering charges. *Ante* at 568. This representation is wrenched from its context, however. While he does not deny the severity of these charges in the abstract, ***574** he certainly does not concede they are serious enough to warrant forced medication. In fact, Dr. Sell devotes most of his efforts to defending and minimizing the charges of conspiring to murder an FBI agent and witness, not to discussing the fraud and money laundering charges.

More telling still, neither the government nor the district court believe the fraud and money laundering charges *alone* support the forcible administration of medication. The government all but dismisses these counts when arguing about the severity of the charges against him. The government focuses its attention almost entirely on the charges related to the conspiracy to murder the FBI agent and witness. Neither in its brief, nor during oral argument, has the government claimed the fraud and money laundering charges by themselves are serious enough to warrant forced medication. Likewise, the district court acknowledged the conspiracy to commit murder charges tipped the balance in its conclusion that Dr. Sell's alleged offenses were serious enough to warrant the forcible administration of antipsychotic drugs.

Although the majority properly omits the charges of conspiracy to commit murder from its analysis, *ante* at 568 n. 8, the majority inexplicably turns a blind eye to the apparent agreement of all parties that the fraud and money laundering charges alone are insufficiently serious to warrant forcible medication. This course of action is questioned.

This is not meant to suggest the crimes with which Dr. Sell has been charged should not be prosecuted. They will and should be. However, this defendant should not be forced to take antipsychotic drugs in order to be prosecuted for them. The government's interest in forcibly medicating an accused murderer may be essential, but its interest in forcibly medicating an accused thief is not. In my view, these charges are not serious enough to warrant the forced medication of the defendant, who, we must not forget, is a non-dangerous pre- trial detainee cloaked with

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the presumption of innocence. As a result, the government has failed to satisfy the first part of the majority's three-part test.

* * * * * *

The government is not without recourse upon a finding that the charges against Dr. Sell are insufficiently serious to warrant forcible medication. He will not be set free. A civil commitment is in order for him until he becomes competent, or voluntarily agrees to take medication. *See Riggins*, 504 U.S. at 145 (Kennedy, J., concurring) (stating that if the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment). The government asserts that its interest in punishing crime will be diminished by the option of civil commitment. It is true Dr. Sell's criminality will not be adjudicated as the civil commitment unfurls. However, the government's interest in forcing him to stand trial on charges that may result in such limited punishment does not outweigh his substantial rights under the First, Fifth and Sixth Amendments. *See Brandon*, 158 F.3d at 956-61 (enumerating an individual's rights in refusing antipsychotic medication).

I respectfully dissent.

282 F.3d 560

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

FILED
AUG 09 2000
U. S. DISTRICT COURT
E. DIST. OF MO.
ST. LOUIS

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 4:96CR177 DJS
	)	4:97CR290 DJS
CHARLES THOMAS SELL,	)	(Consolidated)
	)	
Defendant.	)	

MEMORANDUM AND ORDER
OF UNITED STATES MAGISTRATE JUDGE

This matter is before the court on the government's motion to involuntarily medicate the defendant using anti-psychotic drugs. The government further requests that the defendant's period of commitment be extended while the defendant is involuntarily medicated. On September 29, 1999, the undersigned held a hearing on the motion. Based on this hearing as well as other matters detailed below, the undersigned makes the following findings of fact and conclusions:

Background and Findings of Fact

On May 16, 1997, defendant Charles Sell was charged in a complaint with making false representations in connection with the payment of health care services in violation of 18 U.S.C. § 1035(a)(2). On that same date, the defendant was arrested and afforded his initial appearance. On May 20, 1997, the government filed a motion for psychiatric examination of the defendant to determine his competency to stand trial. The motion states that the defendant has a history of mental illness, and is described by his employees as irrational and prone to angry and violent outbursts. On May 20, 1997, a magistrate judge granted the motion and the defendant

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was sent to the U.S. Medical Center for Federal Prisoners at Springfield, Missouri, for an evaluation.

On July 2, 1997, a psychiatric evaluation report was received from Springfield, and on July 15, 1997, a hearing was held to determine the defendant's competency to stand trial. At the hearing, the court, without objection, considered the psychiatric evaluation report from Springfield. The report concluded that the defendant was currently competent to stand trial, but that there was a possibility that the defendant could, in the future, develop a psychotic episode, and that his paranoid personality characteristics would color his relationship with his counsel. Based on the report, the judge found the defendant currently competent to stand trial. On July 30, 1997, an indictment was returned against the defendant and his wife charging them with fifty-six counts of mail fraud, six counts of medicaid fraud, and one count of money laundering.

Six months later, on January 22, 1998, a petition was filed alleging that the defendant violated his conditions of release by attempting to intimidate a witness. Based on this petition, a warrant was issued for the defendant's arrest. On January 23, 1998, the defendant was arrested and brought to a magistrate judge's courtroom for his initial appearance. At that point, the defendant was out of control, screaming, shouting, and using racial epithets. Because of the defendant's out-of-control behavior and at the request of the U.S. Marshals Service, the judge attempted to conduct the initial appearance in the Marshal's secure area. As the proceeding commenced, Dr. Sell began screaming and shouting personal insults at the judge and, as the judge started to advise the defendant of his rights, the defendant spat directly in the judge's face. In the judge's words, the defendant appeared "totally out of control."

On January 26, 1998, a bond revocation hearing was held and shortly thereafter, the defendant's bond was revoked and he was ordered detained. One factor considered by the judge was the report of a psychiatrist who was seeing Dr. Sell as a part of Dr. Sell's conditions of release. The psychiatrist reported that, as of January 21, 1998, Dr. Sell's mental condition was worsening. He said that Dr. Sell was not sleeping at night because he was staying up guarding his doors because he was expecting the FBI to "come busting through the door." The psychiatrist said that while Dr. Sell was not an immediate danger, this status could change at any time and Dr. Sell could become a danger. He said Dr. Sell needed to be treated with anti-psychotic medications.

On April 23, 1998, the defendant was charged in a second indictment with one count of conspiring to murder a witness in his fraud case and conspiring to murder an FBI agent who was working on the case, four counts of attempting to murder two separate witnesses in the case, and two counts of attempting to murder an FBI agent.

During the next several months, this matter was set for trial on multiple occasions, but was continued at the request of both parties. The defendant appealed at least two matters to the Court of Appeals during this time period. On February 10, 1999, the defendant filed a motion asking this court to hold a hearing and determine whether or not Dr. Sell was competent to proceed to trial in this matter. The motion stated that in the opinion of Dr. Sell's psychiatrist and psychologist, Dr. Sell was not currently competent to proceed to trial. On February 22, 1999, the undersigned granted the government's separate motion to have Dr. Sell examined at the Springfield Medical Center to aid in the determination of the defendant's competency to stand trial. On April 14, 1999, the undersigned held a hearing to determine Sell's competency. Based

on the evidence presented at that hearing, and without objection from the defendant, the undersigned found that the defendant was presently suffering from a mental disease or defect rendering him mentally incompetent to stand trial, particularly finding that the defendant was not competent to assist properly in his defense.

On April 14, 1999, based on this finding, the undersigned determined that Dr. Sell was incompetent to stand trial, and ordered that Dr. Sell be hospitalized for treatment in the U.S. Medical Center for Federal Prisoners for a period not to exceed four months to determine whether there was a substantial probability that the defendant would attain the capacity to allow his trial to proceed.

In June, 1999, an administrative hearing regarding the involuntary administration of anti-psychotic medication was held at the U.S. Medical Center for Federal Prisoners. Pursuant to this court's order, defendant's counsel was allowed to participate in the hearing. In July of 1999, based on findings made by the hearing officer, the involuntary administration of anti-psychotic medication was authorized by the institution.

On August 20, 1999, the undersigned granted defendant's motion for a judicial hearing to determine the propriety of the administration of anti-psychotic medication, and stayed the administration of the medication by the institution pending the hearing. The undersigned also granted the institution's request to grant a 120-day extension of his commitment to Springfield. As stated, the hearing was held on September 29, 1999. The evidence, as submitted at the hearing by the testimony of a psychiatrist and psychologist from the Springfield medical center, as well as the affidavit of the defendant's psychiatrist and other defense exhibits revealed the following:

Dr. Richart DeMier, Ph.D., is a staff psychologist at the Medical Center for Federal Prisoners, Springfield, Missouri, and has been so employed for approximately five years. Dr. DeMier is the staff psychologist primarily responsible for the diagnosis of Dr. Sell's illness and for the day-to-day treatment of Dr. Sell. He has been in at least weekly contact with Dr. Sell, both during his first admission to the hospital, and during his most recent commitment in April, 1999. In addition to very frequently seeing and talking to Dr. Sell, DeMier also receives frequent reports from the staff of the medical center who are in daily contact with the defendant.

Based on these interviews and other information, Dr. DeMier has concluded that Dr. Sell is suffering from delusional disorder of the persecutory type, a very serious and potentially dangerous psychosis. Dr. DeMier also concluded that the defendant's judgment is very poor and becoming worse each day that he is not treated with anti-psychotic medications.

As evidence of this deterioration, in July, 1999, Sell formed an infatuation with a female nurse on the staff of the medical center. He told the nurse that she was very special to him, and that the nurse did not realize how much she meant to him. When told that it was inappropriate to talk to the nurse in this familiar manner, he did not stop the familiarity, and told the nurse and other staff members that he could not help himself, and that he could not stop this conduct. Although he did not touch the nurse, he said that he would do so if she asked him, and the nurse considered him to be a danger to her safety. He also told staff members that he could "smell" the nurse's presence. During this same time, the defendant also told DeMier that he was afraid to be transferred to a county jail because he was certain that the FBI was actively involved in a plan to have him murdered. He also told DeMier that DeMier would be ordered to release him from custody so he could go to Bosnia with his army reserve unit, as this was essential to the

national security. He also told DeMier that DeMier would be personally called before Congress to explain his mishandling of Dr. Sell's case.

Because of Sell's specific focus on the nurse, his increasing personalization of the perceived murder plot by the FBI, his personalization of animosity toward DeMier along with the defendant's history of committing an assault on a federal judge, and the fact that the defendant was charged with conspiring to murder an FBI agent and two witnesses in his case, DeMier concluded at the September 29, 1999 hearing, that the defendant was an immediate risk to commit violent acts, and was dangerous to himself and to others. DeMier said that because Sell believes that people (including the FBI and DeMier) are out to get him, given Sell's mental condition, Sell is likely to "protect himself" by harming people who have no intention of doing any harm to him. The fact that Sell's delusional beliefs have become more focused makes Sell an immediate risk of violence to himself or others.

Because of this danger, Sell is being held in the most secure area of the Springfield medical center, and is allowed out of his holding area only for short periods of time. Although this ameliorates the defendant's danger to himself and the staff, it does not eliminate this danger because the staff still must have contact with him.

DeMier also believes that, based on his training and experience, the only treatment that will improve Sell's condition is the use of anti-psychotic medications, because there is no other effective treatment for the illness. He further believes that if Sell does not receive anti-psychotic medication, his condition will continue to deteriorate. However, if anti-psychotic medications are administered, it is likely that the defendant will be restored to competency, and that the danger caused to the staff by Sell's condition will be greatly reduced.

DeMier has treated two patients in the recent past for delusional disorder with anti-psychotic medications, and both treatments were successful. One of the patients was restored to competency, and the other patient was greatly improved and rendered not dangerous to the extent that he was released from prison. DeMier also believes that the benefits of using anti-psychotic medications greatly outweigh any risks, and that the use of these medications is the only way to render the defendant not dangerous and to restore him to competency. According to the medical literature, anti-psychotic medication is the treatment of choice for delusional disorder, and delusional disorder responds favorably to the use of anti-psychotic medications.

Dr. James Wolfson, M.D., is a staff psychiatrist at the Springfield medical center and is the consulting psychiatrist on Dr. Sell's case. Based on his interviews of Dr. Sell, and his review of the medical center's records, it is Wolfson's opinion that Sell is psychotic, and that the only way to treat Sell's condition is with anti-psychotic medications. Without this treatment, Wolfson believes that Sell's condition will continue to deteriorate. Further, based on Sell's history and conduct, Sell is currently dangerous, and anti-psychotic medications will greatly reduce the risk of violence by Dr. Sell, and will render him not dangerous.

Dr. Wolfson has treated 1,000 to 2,000 patients with anti-psychotic medications, and has achieved good results in a great majority of these cases. In addition to rendering Sell less dangerous, Wolfson believes that there is a good chance that Sell can be restored to competency by the use of anti-psychotic medications. In the recent past, Wolfson has used anti-psychotic medications on five patients with delusional disorder, and has been successful in restoring four of these patients to competency, an eighty per cent success rate.

Further, Wolfson vehemently disagrees with the defendant's psychiatrist, that anti-psychotic drugs are not effective and should not be used in the treatment of delusional disorder. Wolfson says that the medical literature, his own experience, and the very experts relied on by the defendant's psychiatrist, show that anti-psychotic medications, when combined with psychotherapy, are effective in the treatment of delusional disorder. Further, even the defendant's psychiatrist agrees that anti-psychotic drugs are effective in the control of agitation and dangerousness in patients with delusional disorder.

According to Wolfson, there are three main side effects involved in using anti-psychotic drugs. The first is tartive dyskinesia and/or distonic reaction. This side effect causes a person to have involuntary body movements of various parts of the body. This is not a permanent side effect, and this condition can be ameliorated by the use of other medications along with the anti-psychotic drugs, or by switching from one anti-psychotic medication to another anti-psychotic medication. The side effect is not life threatening, and as stated is not a permanent side effect, but will go away with the use of other medications or withdrawal of the medication.

Another side effect is that some patients are somewhat sedated by the medication. With newer drugs, this side effect occurs infrequently and can be alleviated by changing the dosage of the medication. Further, because one of the purposes of the medication is to allow patients to assist effectively in the preparation and defense of their cases, Wolfson uses medications that do not significantly sedate the defendant or impair the ability of the defendant to assist in his own defense.

According to Wolfson, the other major serious side effect from the medication is neuroleptic malignant carcinoma which can be fatal. Of the 1,000 to 2,000 patients Wolfson has medicated with anti-psychotic drugs, none have developed this syndrome, and Wolfson has seen this complication occur only twice during his career. According to the medical literature, this condition occurs in about 1 in 10,000 patients who take the medication. Further, Dr. Wolfson desires to medicate the defendant with newer drugs, which have a much lower side effect profile than older medications.

It is also Wolfson's opinion that the only way to treat Sell's condition is with the use of anti-psychotic drugs, and it would be irresponsible and wrong not to use these medications. Without these medications the defendant will continue to suffer from a catastrophic and debilitating illness, from which he is never likely to recover. For all of these reasons, Wolfson believes that the benefits of using the medication far outweigh any risk from the medication in any patient he would treat for this illness, whether or not the person was incarcerated or institutionalized in any way.

At the conclusion of the hearing, both the defendant and the government requested permission to delay briefing the issues presented at the hearing until after a transcript was prepared. After requests for more time to file the memoranda by both parties, the briefs were eventually filed before the court at the end of January, 2000. Almost simultaneously with the filing of these memoranda, on January 31, 2000, Sell's attorneys filed a motion for relief from involuntary commitment stating that he was being illegally held at Springfield beyond the time permitted by the statute, and requesting that he be immediately released. Further, in partial

response to this motion, the government filed a motion for the extension of Dr. Sell's commitment to Springfield on February 3, 2000.

On March 20, 2000, the U.S. Medical Center for Federal Prisoners wrote the court asking that Dr. Sell's commitment be extended. Included in the report is a report from Dr. DeMier on Sell's mental condition. The report states that Sell's condition has deteriorated to the extent that the risk of physical injury to the staff and to Dr. Sell has become greater because of Sell's increased volatility and paranoia. Dr. DeMier also states that Sell's infatuation with the nurse at the facility has worsened to the point that his thoughts about her have outweighed other issues that should be much more important to him. DeMier described Sell's behavior as volatile because it can change suddenly without any apparent reason. In summary, DeMier concludes as follows:

> Anti-psychotic medication remains the only effective treatment for his mental illness. Without the opportunity to treat the defendant, he will continue to suffer from a debilitating and catastrophic illness, and we are placed at increased, even inevitable, risk of harm to the defendant or those charged with his care.

He further states that the use of anti-psychotic medications will provide the defendant with a good chance of being restored to competency.

Conclusions

Based on the above facts, as well as the law stated below, the undersigned orders the involuntary medication of Dr. Sell. In the case of Riggins v. Nevada, 504 U.S. 127 (1992), the court stated as follows:

> Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings, Nevada certainly would have satisfied due

> process if the prosecution had demonstrated and the district court had found that treatment with anti-psychotic medication was medically appropriate and considering less intrusive alternatives essential for the sake of Riggins' own safety and the safety of others.

504 U.S. 127, 135.

Further, in United States v. Morgan, 193 F.2d 252 (4th Cir. 1999), the court stated as follows in ordering the forced medication of a pretrial detainee because the detainee was a danger to himself and others:

> The fact remains, however, that the finding that treatment with anti-psychotic medication was necessary to render Morgan competent to stand trial was accompanied by a finding that such medication was necessary because he is dangerous to himself and to others at Springfield. Although Morgan provides us with no psychiatric evidence supporting a conclusion that the dangerousness finding was made arbitrarily, he essentially requests that we disregard that finding so that we may evaluate the constitutionality of permitting Springfield medical personnel to make the determination of whether to forcibly medicate him solely for the purpose of rendering him competent to stand trial. This we are unwilling to do. We realize that forcibly medicating a pretrial detainee on the basis that such treatment is necessary because he is dangerous to himself or others in the institutional setting might have the incidental effect of rendering him competent to stand trial. However, if such an occurrence would come to pass in the present matter, Morgan would not simply be thrust into the courtroom for trial without additional procedural protections. Rather, he would be statutorily entitled to have a district judge conduct a pretrial examination of his competency to stand trial in the context of an evidentiary hearing at which time he would be represented by counsel and permitted 'to testify, to present evidence, to subpoena witnesses on his own behalf, and to confront and cross examine witnesses who appear at that hearing.' Morgan could be brought to trial only if the government proved to the district judge by a preponderance of the evidence that Morgan was able to understand the nature and consequences of the proceedings against him and to assist properly in his defense...Assuming that the government succeeded in this regard, Morgan may be entitled to even further

> procedural protection should the government forcibly plan to medicate him at any point during trial. Specifically, due process would require the district judge make findings as to the need for and medical appropriateness of such medication during trial. The district judge might also ensure the medication posed no significant risk of altering or impairing Morgan's demeanor in a manner that would prejudice his capacity or willingness to either react to testimony at trial or to assist his counsel.

193 F.3d 252, 264.

In Papantony v. Hedrick, 215 F.3d 863 (8th Cir. 2000) (a civil case filed by a prisoner at the Springfield Medical Center which the Court of Appeals construed as a Bivens action for damages) the court ruled as follows in rejecting the claim:

> A government official is immune from a Bivens suit unless the official's conduct violates a clearly established constitutional right. In Papantony's case the right is far from clearly established. In fact, Papantony as a pretrial detainee likely has no substantive due process right not to be forcibly administered anti-psychotic drugs to render him competent to stand trial. See Riggins v. Nevada, 504 U.S. 127. Finally, although we reject any remedy for Papantony at this time, circumstances could change and anti-psychotic drugs might eventually render Papantony competent to stand trial. If that occurs, this decision will not foreclose a future argument by Papantony that forced medication during trial violates his right to a fair trial. See generally United States v. Morgan, 193 F.2d 252 (4th Cir. 1999).

Given the above law, the undersigned concludes that the government has made a substantial and very strong showing that Dr. Sell is a danger to himself and others at the institution in which he is currently incarcerated. In addition, the government has shown that anti-psychotic medication is the only way to render him less dangerous, and that the serious side effects of the medication will be ameliorated by newer drugs and/or changing of the drugs. Further, the benefits to Dr. Sell of using the medication far outweigh any risks, the use of such

medication is necessary, and a strong showing of the necessity to use this medication has been made by the government. In addition, as in United States v. Morgan, supra, an ancillary effect of the use of the medication, because Dr. Sell is dangerous, is that there is a substantial probability that Dr. Sell will be returned to competency.

In United States v. Weston, 206 F.3d 9 (D.C. Cir. 2000), the court held that even if a court finds that forced medication is necessary and essential to the defendant's safety and the safety of others, the court must also consider the need for the medication in restoring competency, and the effect of the medication on the defendant's ability to assist in his defense. In the case now at bar, the record reveals that anti-psychotic medication is the only way to render the defendant both not dangerous and to make him competent to stand trial. If Dr. Sell is not medicated, he will continue to suffer from a catastrophic and debilitating illness, will remain incompetent, and remain a danger. According to Dr. Wolfson, if the defendant is medicated and receives psychotherapy along with the medications, his delusions will diminish to the extent that they will no longer control his thinking and actions. Given this, Dr. Wolfson's opinion is that the defendant has a good chance of becoming competent and less dangerous. Because the defendant's delusions will no longer control or dominate his thoughts and actions, the undersigned concludes that if medicated, the defendant will be able to communicate with his counsel in a rational manner in order to assist in his defense. Further, Dr. Wolfson intends to use atypical anti-psychotic drugs with a low side effect profile when medicating Dr. Sell. Dr. Wolfson also intends to avoid sedating Dr. Sell, because his purpose is to allow him to participate meaningfully in his trial. He likewise intends to avoid all other side effects to the

maximum extent possible. Thus, the undersigned concludes that the standard required in Weston, supra, has been met in the case now at bar.

Based on the above, the undersigned concludes that the government has shown in as strong a manner as possible, that anti-psychotic medications are the only way to render the defendant not dangerous and competent to stand trial on the very serious and violent offenses for which he now stands indicted. There are no other less restrictive means by which this may be accomplished, including other medications, psychotherapy without the use of anti-psychotic medications, and locking down the defendant, all of which have either been attempted or considered. Therefore, the undersigned concludes that Dr. Sell must be involuntarily medicated with anti-psychotic medications.[1]

Based on the above facts and law, the undersigned grants the government's motion for extension of his commitment for a 120-day period of time, because there is a substantial probability that within such period of time, Dr. Sell will attain the capacity to permit the trial to proceed if medicated. The undersigned further notes that because the defendant has (as is his absolute right) refused to take anti-psychotic medication, and explored all legal means possible to avoid taking the medication, Dr. Sell has not yet been treated with the only treatment which the undersigned has concluded will render him less dangerous and competent. Therefore, based on the above, the government's motion for extension of commitment is granted.

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[1] The defendant cites United States v. Brandon, 158 F.3d 947 (6th Cir. 1998) as controlling in this matter. Although the undersigned believes that the government has met the standards required by Brandon, it solely involves the legality of the medication of a non-dangerous pretrial detainee unlike the case now at bar.

The defendant also alleges that he is being unlawfully held beyond the time authorized by the statute, and that it is unconstitutional to indefinitely commit him for purpose of rendering him competent. In United States v. Kokoski, 82 F.3d 411 (4th Cir. 1996), the court ruled that the defendant's right to due process was not violated by an 18-month commitment to obtain his competency. In so holding, the court stated as follows:

> He first argues that § 4241(d) limits the time he may be hospitalized to eight months...We reject this argument. We think 'an additional reasonable period of time' means some reasonable but statutorily undefined period of time. United States v. Ecker, 30 F.3d 966, 969 (8th Cir. 1994). Here we find that Kokoski's 18-month confinement was reasonable. Every report issued before the Butner staff declared Kokoski competent indicated he was likely to regain competency. The final six months of his confinement were necessary to challenge and clarify Butner's conclusion. In light of the district court's careful adherence to statutory procedures, we believe Kokoski's confinement was reasonable. See id. (confinement during seven competency evaluations spanning nearly four years not unreasonable).

82 F.3d 411, 1996 WL 181482. Further, in United States v. Ecker, 30 F.3d 966 (8th Cir. 1994), a case involving at least five competency commitments over a three and a half year period of time, the court stated as follows: "The overall determination of ultimate competency to stand trial can extend over a reasonable period." Id. at 970. Having considered the background and evidence, the Eighth Circuit held that there "was no clear violation of the statute in ordering each of the several competency evaluations nor an unreasonable overall delay in the proceedings under the circumstances." Id. at 970.

Based on the above law, the defendant's request for relief from involuntary commitment should be denied.

Therefore,

IT IS HEREBY ORDERED that the government may involuntarily medicate the defendant with anti-psychotic drugs consistent with this memorandum. It is also **ORDERED** that this portion of the court's order shall be stayed for fourteen (14) days to allow the defendant to appeal this portion of the order if he so desires. Any further stay must be granted by a United States District Judge or the United States Court of Appeals.

IT IS FURTHER ORDERED that the government's request for an extension of the defendant's commitment be **granted**, and that his commitment is ordered extended for a 120-day period of time effective as of the date of this order.

IT IS FURTHER ORDERED that defendant's request for relief from involuntary commitment should be **denied**.

IT IS FURTHER ORDERED that this Memorandum and Order supersedes the Interim Order entered by this court on July 28, 2000.

UNITED STATES MAGISTRATE JUDGE

Dated this 9th day of August, 2000.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

FILED
APR 4 2001
U. S. DISTRICT COURT
EASTERN DISTRICT OF MO
ST. LOUIS

UNITED STATES OF AMERICA,

Plaintiff,

vs.

CHARLES THOMAS SELL,

Defendant.

No. 4:97CR290-DJS
4:98CR177-DJS

ORDER

Defendant is a pretrial detainee who has been found incompetent to stand trial and who is currently remanded for treatment to the United States Medical Center for Federal Prisoners at Springfield, Missouri ("USMC"). By order dated August 9, 2000, a United States Magistrate Judge granted the government's request for an order authorizing the involuntary administration of anti-psychotic drugs to defendant. On August 18, 2000, the magistrate judge denied defendant's motion seeking reconsideration of the August 9 order, a reopening of the September 29, 1999 hearing in the matter, and the production of certain evidence. The matter is now before the Court on defendant's appeal of the magistrate judge's denial of defendant's motion for reconsideration of the involuntary medication ruling. For reasons explained fully below, the Court here affirms the magistrate judge's ruling that substantive due process does not preclude the forcible

(29)

administration of anti-psychotic medications to defendant in this case.

Pursuant to 28 U.S.C. §636(b)(1)(A), defendant's motion concerning involuntary medication was referred to the magistrate judge for his consideration and ruling. Order of 7/30/99 [Doc. #323/#188]. Section §636(b)(1)(A) provides that a district judge may "reconsider any pretrial matter under this subparagraph (A) where it has been shown that the magistrate's order is clearly erroneous or contrary to law." As indicated above, defendant asks this Court to reconsider the magistrate's denial of the motion to reconsider. In his motion to this Court, defendant characterizes the grounds for reconsideration as follows:

> (1) the Magistrate's findings of fact with regard to the side effects of antipsychotic drugs are squarely refuted by the relevant medical literature and by the testimony adduced at the hearing by both the Government and by Dr. Sell; (2) the Magistrate's finding that Dr. Sell is dangerous is clearly erroneous; (3) the Magistrate improperly based its findings of fact upon the Government's anecdotal evidence and upon communications the Government submitted to the Magistrate ex parte in a post-hearing letter; and (4) the Magistrate's conclusions fail to take into account the effect drugging will have on Dr. Sell's ability to receive a fair trial.

Motion [Doc. #372/#232], p.2. After reviewing the legal principles applicable to the issue of involuntary administration of drugs, the Court will address each of these assertions in turn:

Due Process and the Forcible Administration of Anti-Psychotic Drugs

Certain interests deemed sufficiently fundamental to human liberty are protected by the Due Process Clauses of the Fifth and Fourteenth Amendment. A liberty interest in this protected class cannot constitutionally be impinged by government action unless the infringement is narrowly tailored to serve a compelling state interest. See, e.g., Reno v. Flores, 507 U.S. 292, 301-02 (1993). In Washington v. Harper, 494 U.S. 210 (1990), the United States Supreme Court held that a prison inmate's interest in resisting involuntary administration of anti-psychotic drugs had Due Process protection. "The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." Id. at 220; see also United States v. Brandon, 158 F.3d 947, 956-57 (6th Cir. 1998) [applying the strict scrutiny standard to issue of forcible medication of non-dangerous pretrial detainee].

Riggins v. Nevada, 504 U.S. 127 (1992), involved a pretrial detainee:

> Under Harper, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness. The Fourteenth Amendment affords at least as much protection to persons the State detains for trial...Thus, once Riggins moved to terminate administration of antipsychotic medication, the State became obligated to establish the need for [it] and the medical appropriateness of the drug.

Id. at 135 (internal citations omitted).[1] Riggins appears to identify two possibilities for the type of government interest sufficient to override the detainee's protected liberty interest, where medical appropriateness is also shown. These interests are the safety of the detainee and others and the detainee's restoration to competence:

> Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings, Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with anti-psychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others...Similarly, the State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means.

Id. at 135 (internal citations omitted).

The proceedings before the magistrate judge were based on the defendant's motion for a judicial hearing on the issue, rather than on a motion from the government which might have more clearly identified the legal and factual basis on which the involuntary medication was sought. Both dangerousness and the need to restore defendant to competence are touched upon in the record, however,

[1]The Court respectfully suggests that the Eighth Circuit's per curiam opinion in Papantony v. Hedrick, 215 F.3d 863, 865 (8th Cir. 2000), misspeaks when it characterizes Riggins as indicating that a pretrial detainee "likely has no substantive due process right not to be forcibly administered antipsychotic drugs to render him competent for trial."

and the magistrate judge's determination that the forcible administration is permissible appears to be based on both rationales. Memorandum and Order of 8/9/00 [Doc. #367/#227], pp.12-14. The magistrate judge found as follows:

> [T]he undersigned concludes that the government has shown in as strong a manner as possible, that anti-psychotic medications are the only way to render the defendant not dangerous and competent to stand trial on the very serious and violent offenses for which he now stands indicted. There are no other less restrictive means by which this may be accomplished, including other medications, psychotherapy without the use of anti-psychotic medications, and locking down the defendant, all of which have either been attempted or considered. Therefore, the undersigned concludes that Dr. Sell must be involuntarily medicated with anti-psychotic medications.

Id. at 14.[2]

Side Effects and Effectiveness of Anti-Psychotic Drugs

Defendant first contends that the magistrate judge's findings of fact on the issue of side effects are erroneous. The magistrate judge's order reviews the evidence concerning three potential side effects: tardive dyskinesia, sedation, and neuroleptic malignant carcinoma. The magistrate judge found that "the serious side effects of the medication will be ameliorated by

[2]This portion of the ruling belies defendant's contention that the magistrate judge "wholly failed to address the question of whether or not medication is necessary to render Sell competent for trial," a contention that need not be further addressed. Def. Supplemental Memorandum in Support of Motion to Reconsider [Doc. #403/#262], p.5.

newer drugs and/or changing of the drugs," and that "the benefits to Dr. Sell of using the medication far outweigh any risks." Memorandum and Order of 8/9/00 [Doc. #367/#227], p.12. Tardive dyskinesia is identified as involuntary body movements. The magistrate judge's order indicates that this effect is not permanent and can be ameliorated by supplemental medications or, as necessary, a change in the anti-psychotic medication. Id. at 8. In his motion to this Court, defendant cites to the testimony of a government witness, clinical psychologist Richard DeMier, that the condition is permanent. Motion [Doc. #372/#232], p.9, *citing* Transcript of 9/29/99 Hearing [Doc. #341/#205], p.32.

In his reconsideration ruling of August 18, 2000, the magistrate judge indicated that even if tardive dyskinesia is a permanent effect, he would continue to conclude that "the potential benefit of treatment far outweighs any risk." Memorandum [Doc. #371/#230], p.1. Even under defendant's view of this disputed fact, then, the magistrate judge's conclusion is unaffected. That being the case, any error in his factual finding per se does not require reconsideration by this Court. Furthermore, having reviewed the record upon which the magistrate judge acted, this Court would concur in the conclusion that the medical benefits outweigh the medical risks, giving due weight to the range of seriousness of the various risks, to the prospects for alleviating

certain side effects with supplemental medication, and to the fact that a particular side effect may or may not occur in Dr. Sell.

Defendant also makes generalized arguments concerning the efficacy of anti-psychotic drugs. Having considered all the evidence of record before the magistrate judge, and acknowledging that there exist differences of opinion among practitioners in the field, including the experts relied upon by the parties, the Court cannot conclude that the magistrate judge clearly erred in determining that there is a significant potential medical benefit of treatment with anti-psychotics.[3] As is presumably characteristic in cases of delusions, Dr. Sell does not believe himself to be delusional and, not thinking his delusional beliefs are false, he is not persuaded his delusions require treatment. The Court's analysis begins with a sharply different factual premise, however, namely that Dr. Sell suffers from a serious delusional disorder, which currently significantly impairs and misleads his interpretation of reality and his reasoning. Arguments made on his

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[3]The Court notes that in his appeal to this Court, defendant cites to sources which were not of record before the magistrate judge, some of which could not have been, given their more recent vintage. These include an Indiana Law Review, Postgraduate Medicine (2000), and American Journal of Psychiatry (2000). The Court here acting as an appellate court of sorts, and given the applicable standard of review, the Court's consideration of this new evidence appears to be inappropriate. In any event, the Court notes that its conclusions concerning risk/benefit analysis and the efficacy or appropriateness of anti-psychotics in Dr. Sell's case would be unaffected by consideration of these sources.

behalf which neglect to take this into account are therefore necessarily diminished in their persuasiveness and impact.

The principal basis for the finding of incompetency is the interference of defendant's delusional beliefs with his ability to assist in his defense. These are characterized by his own psychiatrist as "systematized persecutory delusions that he is the victim of a government plot to discredit his allegations about widespread illegal behavior by corrupt individuals to spread HIV and kill innocent civilians throughout the world." 9/28/00 Letter of Dr. Cloninger, attached to Def. Supplemental Memorandum in Support of Motion to Reconsider [Doc. #403/#262]. Defendant believes that this prosecution and the government's position as to his incompetency reflect an effort to cover up his knowledge of the government's culpability in the deaths of David Koresh and his followers in the Branch Davidian compound near Waco, Texas in 1993, knowledge defendant claims to have based on his experiences on Army Reserve duty in Texas at that time. Forensic Psychological Report [Sealed Doc. #304/#169], pp.5-6. Another example of defendant's delusional thinking is described in the testimony of defendant's treating clinician at the magistrate judge's evidentiary hearing:

> [W]hen the U.S. Military initially became involved in the Bosnia conflict, Dr. Sell stated that he expected the U.S. Military to come to our facility to secure his release so that he could go to Bosnia. When he was told that that was not likely to happen, he expressed some delusional beliefs that his presence in Bosnia was absolutely essential to the safety of our troops, and if he weren't permitted to go that would meant that it, to

> use his words -- somebody wanted a lot of American boys dead.

Transcript [Doc. #341/#205], p.11. Risks of unpleasant or even dangerous side effects and the impact of anti-psychotic drugs on Dr. Sell's cognitive processes are counterbalanced by the substantial weight of his current impaired and incompetent state, despite Dr. Sell's protestations to the contrary.

Dangerousness

Defendant argues that the magistrate judge's finding that he is currently a danger to himself or others is clearly erroneous. The magistrate judge found:

> Because of Sell's specific focus on the nurse, his increasing personalization of the perceived murder plot by the FBI, his personalization of animosity toward [prison psychologist] DeMier along with the defendant's history of committing an assault on a federal judge, and the fact that the defendant was charged with conspiring to murder an FBI agent and two witnesses in his case, DeMier concluded at the September 29, 1999 hearing, that the defendant was an immediate risk to commit violent acts, and was dangerous to himself and to others. DeMier said that because Sell believes that people (including the FBI and DeMier) are out to get him, given Sell's mental condition, Sell is likely to "protect himself" by harming people who have no intention of doing any harm to him. The fact that Sell's delusional beliefs have become more focused makes Sell an immediate risk of violence to himself or others.

Memorandum and Order of 8/9/00 [Doc. #367/#227], p.6. The dangerous nature of the charges against Dr. Sell, involving a murder plot, is self-evident. The government made little attempt to establish of record before Judge Adelman the particular

circumstances of the incident in which defendant spat in the face of another magistrate judge, but the incident does not appear to be in dispute. These considerations do not support a finding of current or immediate dangerousness in defendant's present setting, however.

The only evidence of record supporting the asserted personalization of hostility toward Dr. DeMier, defendant's treating clinician, is defendant's telling Dr. DeMier that he should be prepared to testify in Congress concerning his conduct in this case. Transcript, p.10. In testimony concerning a variety of delusional beliefs held by defendant, Dr. DeMier testified that defendant "continues to harbor beliefs that if he were moved to a County Jail, the FBI would have him killed." Id. at 11-12. Accepting as true the government's version of the facts concerning defendant's conduct with regard to the nurse, which defendant disputes, the conduct amounted to an inappropriate familiarity and even infatuation with the nurse, but the record does not support the conclusion that the conduct was sufficient to put the nurse in fear of violence from defendant.[4] Even if the trend in defendant's thoughts and feelings is as described in Dr. DeMier's testimony and set forth above, and even if, as Dr. DeMier testified, this trend

[4]This is particularly so because no testimony or other information from the nurse herself was submitted for the record.

suggests an increased risk of violence, the risk is not shown to be particularly great or imminent.

The record does not indicate that defendant has posed a danger to himself or others during the period of his institutionalization at the USMC, and the statements and conduct relied upon for a finding of dangerousness do not suggest a threat of violence to the staff.[5] Without more, this Court deems it clearly erroneous to conclude that defendant presents a danger to himself or others sufficient to constitute a compelling state interest outweighing his interest in refusing anti-psychotic medication. The Court's conclusion in this regard is based both on the relative weight of the facts evidenced in the record and what the Court regards as the appropriate legal standard for a finding of dangerousness for the present purpose. The Court here makes explicit its view that the standard of dangerousness pertinent to the determination now before it concerns defendant's dangerousness *at this time* to himself and to those around him *in his institutional context*. The determination here made would not necessarily bear on any finding concerning defendant's

[5]Defendant was transferred to a locked-down cell as a disciplinary measure after he allegedly disregarded the nurse's directive to leave the nurse's station, but has since been returned to an open ward. See Defendant's Update to Supplemental Memorandum [Doc. #405/#264] and Defendant's Second Update to Supplemental Memorandum [Doc. #408/#267].

dangerousness to himself, the public, or any other particular persons if released from an institutional setting.

The claim of dangerousness may also be a post hoc justification. Notice of the institutional medication hearing was given to defendant as early as April 28, 1999, just two weeks after he was found incompetent to stand trial and ordered hospitalized for treatment. See "Notice of Medication Hearing and Advisement of Rights" form included in Addendum Exh. A to Def. Motion Regarding Involuntary Psychiatric Treatment and Medication [Doc. #322/#187]. The April 28, 1999 notice provided to defendant stated that the proposed treatment was "Antipsychotic medication" and that the reason for such treatment was to "Restore competency to stand trial." Id. Dangerousness in his prison setting was not a basis for the administrative decision to forcibly medicate defendant. See "Involuntary Medication Report" included in Addendum Exh. A to Def. Motion Regarding Involuntary Psychiatric Treatment and Medication [Doc. #322/#187]. Instead, the administrative determination was based on the conclusion that anti-psychotic drugs were medically necessary as treatment for defendant's delusional and possibly schizophrenic state.

Anecdotal Evidence and Ex Parte Materials

Defendant next contends that officials of the USMC improperly communicated with the magistrate judge by letter on

March 20, 2000, and that the ex parte materials should not have been considered by the magistrate judge to support a finding of dangerousness. This communication consists of a letter from the warden and a "Brief Hospitalization Summary and Request for Extension of Commitment" signed by Dr. DeMier, and appears to be intended as a 120-day report on defendant's hospitalization. Particularly in the context of these proceedings, where the issues concerning anti-psychotic medication are so highly contested, the letter and report should have been served by the USMC on counsel for both parties. In any event, given this Court's conclusion on the issue of dangerousness sufficient to outweigh defendant's liberty interest, the issue need not be further addressed.

The remainder of this point on appeal consists of argument with the sufficiency of the "anecdotal evidence" supporting the opinions of the government's witnesses, treating psychologist Dr. DeMier and consulting psychiatrist Dr. Wolfson, concerning the safety and efficacy of anti-psychotic medications. The Court has earlier expressed its view that the magistrate judge's findings on these issues were adequately supported by the record, and defendant's additional arguments do not disturb that view. To the extent that defendant argues he should have an opportunity to adduce expert testimony challenging DeMier's and Wolfson's conclusions, the argument is entirely unavailing. Defendant has had every opportunity to offer such testimony, at or

in the substantial period of time since the evidentiary hearing held on September 29, 1999.

Defendant's Trial Rights

Finally, defendant argues that the forcible administration of anti-psychotic medication will adversely affect his ability to obtain a fair trial by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom and/or by rendering him unable or unwilling to assist counsel. If defendant's medication renders him unable or unwilling to assist counsel, an unfair trial will not occur. A showing that he is unable to assist properly in his defense would result in a continued finding that defendant is not be competent to stand trial.

That the effects of medication might prejudice the defense at trial is a serious issue, but not one which can preclude forcible medication based on the necessarily generalized manner in which the argument must be presented at this time. The issue is, in effect, premature. Until defendant is treated with anti-psychotic medication, its effects on his demeanor cannot reasonably be assessed. In its appellate role, the Court is unpersuaded that the magistrate judge's conclusion in favor of forcible medication is the result of legal or factual error on the issue of medication's impact on defendant's trial rights.

In its capacity as the trial court in this case, the Court here states that if medication is administered and the defense presents argument and evidence concerning its adverse effect on Dr. Sell's ability to defend himself, the Court will give the issue careful consideration. The Court commends to the parties the careful treatment of the trial rights issue by Judge Sullivan of the United States District Court for the District of Columbia in his recent decision in the Weston case, on the basis of a substantially more complete record. United States v. Weston, __ F.Supp.2d ____, 2001 WL 286406 at *15-*19, slip op. at pp.44-57 (D.D.C. March 6, 2001). As Judge Sullivan states:

> The Court will reassess, upon request, its determination regarding the prejudice to Weston's fair trial rights resulting from medication when testimony about the actual, not hypothetical, impact of the medication is available. The Court is confident that any such review will not come too late to prevent impairment of Weston's rights. However, since Weston's reaction to the medication is, at this point, unknown, by proceeding to medicate him, the government risks the possibility of forfeiting its right to bring Weston to trial. Nevertheless, the Court is reasonably confident, based on the persuasive expert testimony, that any prejudice that might arise would occur with ample time for the Court to revisit these issues.
>
> If Weston is medicated and his competency is restored, the Court is willing to take whatever reasonable measures are necessary to ensure that his rights are protected. This may include informing the jurors that Weston is being administered mind-altering medication, that his behavior in their presence is conditioned on drugs being administered to him at the request of the government, and allowing experts and others to testify regarding Weston's unmedicated condition, the effects of the medication on Weston, and the necessity of medication to render Weston competent to stand trial.

Id. at *19, slip op. at 56-57.

Alternative Basis for Affirmance

The Court reverses the finding below that defendant's dangerousness is a sufficient basis to override his protected liberty interest in refusing anti-psychotic medication at this time. The Court may, however, affirm the magistrate judge on any ground supported by the record, and the Court concludes there is such an alternate ground in this case. See Marolt v. Alliant Techsystems, Inc., 146 F.3d 617, 621 (8th Cir. 1998). As earlier noted, the magistrate judge concluded that the forcible administration of anti-psychotic medication was supported by the government's strong showing that such drugs "are the only way to render the defendant not dangerous and competent to stand trial on the very serious and violent offenses for which he now stands indicted" and that "[t]here are no other less restrictive means by which this may be accomplished." Memorandum and Order of 8/9/00 [Doc. #367/#227], p. 14 (emphasis added). Under Riggins, the government's inability to "obtain an adjudication of [defendant's] guilt or innocence by using less intrusive means" may be a compelling interest which overrides defendant's liberty interest against taking the drugs.

This Court agrees with the magistrate judge that this is such a case. The interest in adjudication of the charges is less

compelling in cases involving lesser offenses. Here, in addition to 63 counts involving mail fraud, Medicaid fraud and money laundering, defendant is charged with conspiring to kill, and attempting to kill, a witness and an FBI agent. The seriousness of these charges contributes greatly to the compelling strength of the government's interest in adjudicating defendant's guilt. See United States v. Weston, ___ F.Supp.2d ___, 2001 WL 286406 at *14, slip op. at pp.42-43 (D.D.C. March 6, 2001).

In summary, the Court concludes that the record supports three findings: (1) that anti-psychotic drugs are medically appropriate for defendant, (2) that they represent the only viable hope of rendering defendant competent to stand trial, and (3) that the administration of such drugs appears necessary to serve the government's compelling interest in obtaining an adjudication of defendant's guilt or innocence of numerous and serious charges. These findings yield the conclusion that defendant's substantive due process rights do not preclude the involuntary administration of anti-psychotic medication.

Accordingly,

IT IS HEREBY ORDERED that defendant's motion to reconsider the magistrate judge's August 21, 2000 order [Doc. #372/#232] is denied.

IT IS FURTHER ORDERED that defendant's motion to reconsider and request for discharge from custody or for a hearing pursuant to 18 U.S.C. §4246(e) [Doc. #407/#266] is denied.

IT IS FURTHER ORDERED that the magistrate judge's order permitting the involuntary administration of anti-psychotic medication to defendant Charles Sell is stayed for fourteen (14) days to permit defendant to take an appeal from this ruling. Any further stay must be granted by the United States Court of Appeals.

Dated this 4th day of April, 2001.

United States District Judge

UNITED STATES COURT OF APPEALS

FOR THE EIGHTH CIRCUIT

No. 01-1862

United States of America,

Appellee,

vs.

Charles Thomas Sell,

Appellant.

Association of American Physicians & Surgeons, Inc., et al.,

Amici on Behalf of Appellant.

Order Denying Petition for Rehearing and for Rehearing En Banc

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

Judges Loken, Murphy, Bye, and Riley would grant the petition for rehearing en banc.

Judge McMillian took no part in the consideration of this case.

(5128-010199)

May 7, 2002

Order Entered at the Direction of the Court:

Michael E. Gans

Clerk, U.S. Court of Appeals, Eighth Circuit

IN THE SUPREME COURT OF THE UNITED STATES

DR. CHARLES THOMAS SELL, D.D.S.
Petitioner,

v.

THE UNITED STATES OF AMERICA
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

Petitioner Charles Thomas Sell, D.D.S., ("Dr. Sell") respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit.

I. The Petition Should Be Granted To Determine Whether The Government Can Violate An Innocent Individual's Fundamental Right To Bodily Integrity By Injecting Him With Permanently Mind-Altering Psychotropic Drugs Against His Will Solely Because It Believes That There Is A Chance To Medicate The Individual Into Drug-Induced "Competence" For Trial.

This is a case of first impression, inasmuch as it involves a non-dangerous pretrial detainee. Until now, Supreme Court jurisprudence regarding medication of pretrial detainees has only considered the quantum of due process required when the government seeks to medicate a pretrial detainee for the penological interest of maintaining prison safety. See Riggins, 504 U.S. at 127. This Court has never determined whether, consistent with substantive due process, the government can take away an individual's Constitutional right to bodily integrity by forcibly medicating that person, based solely upon the government's assertion that the individual is guilty of a non-violent crime. This

Court's prior jurisprudence in Winston v. Lee, 470 U.S. 753, 767 (1985) and Rochin v. California, 342 U.S. 165, 171-74 (1952), confirms that forced medication of Dr. Sell will violate his Constitutional rights. Under the stark circumstances of this case, this Court should confirm that the right to bodily integrity is a fundamental right, which should not be overridden absent a demonstration of a compelling interest from the government.

Dr. Sell's case presents a unique opportunity to consider these issues for two reasons. First, as determined by the lower courts, Dr. Sell has not demonstrated any violence against himself or others while confined. The sole motive for the government's actions, as noted above, is its desire to prosecute Dr. Sell. Second, because the decision to medicate Dr. Sell was based upon non-violent charges, the government's interest in bringing him to trial cannot be deemed compelling. In a nutshell, this Court needs to address the issues of when an individual's right to be free from unwanted medication ends, and when the government's ability to medicate a non-violent person against their will begins. That line has been unconstitutionally transgressed in the courts below. Also, lower state and federal courts across the nation need guidance on this critical question.

A. The petition should be granted because the right to bodily integrity is a fundamental right.

Any analysis of an individual's substantive rights under the Constitution begins with the threshold question of whether the challenged state action implicates a fundamental right. Washington v. Glucksberg, 521 U.S. 702, 720-21 (1997); Mills v. Rogers, 457 U.S. 291, 299 (1982) (recognizing that forcible medication of an individual implicates both procedural and substantive rights). Failure to address this question results, necessarily, in a Constitutionally standardless exercise.

Petitioner notes that this Court has never specifically ruled that the right to be free from unwanted medical treatment is a fundamental right. See Cruzan v. Missouri Dep't of Health, 497 U.S. 261, 304-05 (1990) (Brennan , J., dissenting) (stating that majority failed to consider whether right to bodily integrity was fundamental); Riggins, 504 U.S. at 136 (stating Court could not reach question of substantive rights); Washington v. Harper, 494 U.S. 210, 229 (1990) (assuming, without deciding, that right to refuse medication is at least substantial). The determination of whether a fundamental right is implicated, however, remains critical. It is critical because the nature of the right affected by the government's proposed actions is a prerequisite to determining the applicable standard by which the government's actions are judicially reviewed. The District Court and the Court of Appeals in the instant case failed to determine whether Dr. Sell's right to resist forcible medication was fundamental. See App. 6, 44-45. By doing so, their analyses are without the necessary Constitutional bedrock.

In determining whether a fundamental right exists, it is necessary to examine "our Nation's history, legal traditions, and practices." Glucksberg, 521 U.S. at 710. Even before the Constitution's ratification, the common law recognized that the touching of a person without consent or legal justification constituted a battery. See Cruzan, 497 U.S. at 269. The common law and this Court's ruling in other cases demonstrate quite plainly that forcibly medicating a non-violent detainee involves a fundamental right.

This Court has previously ruled that the right to bodily integrity is fundamental. See Glucksberg, 521 U.S. at 720; Planned Parenthood v. Casey, 505 U.S. 833, 852 (1992) (finding fundamental right for woman to have abortion); Griswold v. Connecticut, 381 U.S. 479, 521 (1965) (recognizing right to use contraceptives is fundamental); Rochin,

342 U.S. at 171-74 (finding government cannot force individual to take an emetic based on suspicion that individual swallowed morphine capsules). A right is fundamental when it involves "the most intimate personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." See Casey, 505 U.S. at 851. Making a determination about one's own psychology - one's own mental state - and about one's own muscular control are the most important personal decisions an individual can make. "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." Id.

Acceptance of the Eighth Circuit's decision to narrow the fundamental liberty interest in self-determination of medical issues will adversely affect and overrule, sub silentio, existing law relating to the control of medical decisions concerning pregnant women and by those opposing certain medical treatment on religious and other grounds. Ferguson v. Charleston, 532 U.S. 67, 68 (2001) (refusing to allow drug testing of pregnant women for prosecutorial purpose); Cruzan v. Harmon, 760 S.W.2d 408, 412 n.4 (Mo. 1988) (collecting cases regarding right to refuse medical treatment).

Indeed, in Cruzan, this Court previously acknowledged that the right of an individual to refuse unwanted medical treatment is protected by the Fourteenth Amendment. Cruzan, 497 U.S. at 78-79. Speaking through Chief Justice Rehnquist, this Court reiterated:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Id. at 269 (citations omitted). Because "our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination," state incursions into the body are deemed repugnant to the interests protected by the Constitution. Id. at 287 (O'Connor, J., concurring); Chandler v. Miller, 520 U.S. 305 (1997) (finding state's requirement that candidates for public office take drug tests is unconstitutional). Not surprisingly, therefore, the trend of modern authority recognizes that an individual has a fundamental right to avoid forced medication. See United States v. Brandon, 158 F.3d 947, 957 (6th Cir. 1998) (recognizing fundamental right in avoiding forcible medication); Bee v. Greaves, 744 F.2d 1387, 1395 (10th Cir. 1984) (applying analysis similar to strict scrutiny); Doe v. Dyett, No. 84 Civ. 6251-KMW, 1993 WL 378867, *2 (S.D.N.Y. Sept. 24, 1993) (recognizing right to refuse administration of drugs as fundamental); Conservatorship of Wendland, 28 P.3d 151, 154 (Cal. 2001) (determining incompetent adult has fundamental right to refuse treatment); Steele v. Hamilton County Community Mental Health Bd., 736 N.E.2d 10, 15 (Ohio 2000) (finding right to refuse medical treatment is a fundamental right in our country); Steinkruger v. Miller, 612 N.W.2d 591, 596 (S.D. 2000) (holding persons involuntarily committed have a federal Constitutionally protected liberty interest to refuse the administration of psychotropic drugs); In re Conservatorship of Foster, 547 N.W.2d 81, 85 (Minn. 1996) (finding the right to be free from intrusive medical treatment is a fundamental right); In re C.E., 641 N.E.2d 345, 351-52 (Ill. 1994) (same); Rasmussen by Mitchell v. Fleming, 741 P.2d 674, 682 (Ariz. 1987) (same); In re Schuoler, 723 P.2d 1103, 1107-08 (Wash. 1986) (same); Andrews v. Ballard, 498 F. Supp. 1038, 1045-48 (S.D. Tex. 1980) (stating right to refuse treatment encompassed in right to privacy). Accordingly, this Court's jurisprudence suggests the

Constitutional answer to the question of whether the government can forcibly medicate a non-violent detainee against his will: No.

Significantly, the forced administration of psychotropic drugs is more serious than other intrusions into the body. As this Court has previously recognized, "[t]he forcible injection of medication into a nonconsenting person's body . . . represents a substantial interference with that person's liberty and [i]n the case of antipsychotic drugs . . . that interference is particularly severe." Riggins, 504 U.S. at 134 (citations omitted). The forcible medication of Dr. Sell will permanently alter his mind and identity and will substantially infringe his First, Fifth, Sixth and Ninth Amendment rights.[2] "The purpose of the drugs is to alter the chemical balance in a patient's brain. . . . While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects." Harper, 494 U.S. at 229. Once such an interest is infringed by the government, it cannot be restored. The right to bodily integrity is a fundamental right.

Moreover, the efficacy of antipsychotic drugs in cases of delusional disorder is uncertain at best. (See, e.g., Transcript of September 29, 1999 Involuntary Medication Hearing at ROA at 526, et seq.) (Judge Stohr acknowledging the disagreement among experts); (ROA at 589). There were three sources of evidence on the question of the medical appropriateness of psychotropic medication for individuals suffering from delusional disorder presented at the hearing before the magistrate judge: the testimony of the Bureau of Prisons witnesses, Drs. DeMier and Wolfson; the affidavit of Dr. Robert

[2] See Bee, 744 F.2d at 1394 and cases cited therein (recognizing decision whether to accept treatment with antipsychotic drugs also falls within privacy interests protected by First Amendment).

Cloninger; and a report from Dr. Daniel Greenstein from the Federal Bureau of Prisons Institution of Metropolitan Correctional Center, a forensic psychologist. While Drs. DeMier and Wolfson, who were advocating medicating Dr. Sell, testified that the use of antipsychotic medication was medically appropriate, Dr. Cloninger's affidavit was clear that "there is no evidence that [antipsychotic medications] are beneficial for patients with delusional disorder." (ROA at 414). The report of Dr. Greenstein stated that delusional disorders do not typically respond to medication or psychotherapy. In fact, the very text relied upon by Drs. DeMier and Wolfson as authoritative, the Comprehensive Textbook of Psychiatry, states that there are no controlled studies reported to support the practice of treating delusional disorder with antipsychotic medication. COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, 1048 (4th ed.). Ordering involuntary medical treatment presupposes that the treatment is medically appropriate, Riggins, 504 U.S. at 127-28, which is not the case here.

Because Dr. Sell's right to bodily integrity is fundamental, this petition should be granted.

B. The government must establish a compelling or "extraordinary" interest in trying an individual for a non-violent crime in order to override his fundamental right.

The government wishes to override Dr. Sell's fundamental right to be free from bodily intrusion under the First, Fifth, and Ninth Amendments and his Sixth Amendment trial rights, so that it can try him for defrauding an insurance company. In United States v. Brandon, the Sixth Circuit determined that the charges brought against the defendant were insufficient for the government to prove it had a compelling interest. 158 F.3d at 961 (discussing charge of sending threatening letter in the mail); see also Bee, 744 F.2d

at 1395 (stating "needs of the individual, not the requirements of the prosecutor, must be paramount where the use of antipsychotic drugs is concerned"); Winston, 470 U.S. at 766-67 (holding government's desire to prosecute defendant did not outweigh defendant's Fourth Amendment rights); see also United States v. Gomes, 289 F.3d 71 (2d Cir. 2002) (labeling government's interest as fundamental). In the instant case, the lower courts labeled the government's interest as "essential," without ever deciding whether the interest was compelling. See United States v. Sell, 282 F.3d 560, 567 (8th Cir. 2002). Because a fundamental right is at stake, the government must demonstrate a compelling interest.

While this Court has never considered whether the government can violate a pretrial detainee's Constitutional right of bodily integrity without asserting any penological objectives, this Court's prior rulings mandate the Constitutional answer.[3] It is undisputed that the government may detain a person suspected of committing a crime prior to an adjudication of guilt. See Gerstein v. Pugh, 420 U.S. 103, 111-14 (1975). However, prior to conviction, an individual committed to pretrial detention has not been adjudged guilty of any crime. While incarcerated, therefore, a pretrial detainee must be presumed to be innocent of alleged, prior criminal conduct. See Bell v. Wolfish, 441 U.S. 520, 582 (1979) (Stevens, J., dissenting). "The principle that there is a presumption of innocence in favor of the accused is the undoubted law, axiomatic and elementary, and

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[3] The district court opinion and the panel opinion afford Dr. Sell, a pretrial non-dangerous detainee, less due process rights than those afforded convicted felons in established case law. A convicted felon cannot be involuntarily medicated unless he is a danger to himself or others within the prison setting and the medication is deemed medically appropriate. Harper, 494 U.S. at 227. By permitting the involuntary medication of a non-dangerous pretrial detainee, the court is fashioning a test that affords an individual presumed innocent with less rights and protections than those of a convicted individual who can only be medicated if dangerous.

its enforcement lies at the foundation of the administration of our criminal law." Coffin v. United States, 156 U.S. 432, 453 (1895).

In Riggins, this Court states:

> [A]bsent an extraordinary showing by the State, the Due Process Clause prohibits prosecuting officials from administering involuntary doses of antipsychotic medicines for purposes of rendering the accused competent for trial.

504 U.S. at 139 (Kennedy, J., concurring) (expressing doubt that the government will be able to make such a showing in most cases).

Petitioner respectfully submits that because the effects of psychotropic drugs on an individual may cause permanent changes in brain chemistry and muscular control, forcibly medicating that individual for the sole purpose of inducing "competence," when the individual has not been found guilty of a crime and still enjoys the presumption of innocence, can only be justified by a government interest of the highest order.

Here, the government's only basis for medicating Dr. Sell is the government's belief that Dr. Sell is guilty of non-violent crimes, involving only economic losses. This interest cannot be compelling enough to overcome Dr. Sell's Constitutional rights.[4] See Brandon, 158 F.3d at 947, 960-61. As noted by the Nevada Supreme Court after remand: "[W]hen I balance the need to bring insane persons to justice against the ignominy of forcing mind-altering drugs down the throats of persons who are presumed to be innocent, I opt in favor of the rights of the individual as against the rights of the State." Riggins v. Nevada, 860 P.2d at 706 (Springer, J., dissenting).

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[4] This is especially so, considering the statute specifically contemplated civil commitment as an alternative remedy. See 18 U.S.C. § 4246. "I should think that any alternative would be less intrusive than toying with an accused's brain chemistry." Riggins v. Nevada, 860 P.2d 705, 707 (Nev. 1993) (Springer, J., dissenting).

Dr. Sell's rights under the common law and under the Constitution were not extinguished after the government charged him with a crime. This Court has recognized the significant Constitutional rights retained by pretrial detainees and has previously only limited those rights when the safety of the pretrial detainee, fellow prisoners or the prison staff was at issue. Riggins, 504 U.S. at 134-35. Indeed, this Court has previously held that prosecutorial motive alone is not enough to violate an individual's Constitutional rights. Winston, 470 U.S. at 766-67 (holding government's desire to prosecute defendant did not outweigh defendant's Fourth Amendment rights); Rochin, 342 U.S. at 171-74 (finding that requiring an individual to ingest an emetic so that police could obtain drugs is unconstitutional).

Although the government possesses an interest in bringing a defendant to trial, not "every charge is sufficient to justify forcible medication of a defendant." See Sell, 282 F.3d at 572 (Bye, J., dissenting) (finding charges against Dr. Sell insufficient to justify forcible medication). While the Eighth Circuit panel also recognized that "[n]ot all charges . . . are sufficient to justify forcible medication of a defendant," it cursorily determined that the charges against Dr. Sell are "serious" and outweighed by the government's essential interest. Sell, 282 F.3d at 568. The Eighth Circuit's one-sentence examination of the nature of the crimes for which Dr. Sell was indicted does not pass Constitutional muster. It does, however, strongly illustrate the need for this Court to explain that the government is required to provide a compelling reason before drugging an individual into "competence." Petitioner also submits that the government cannot present a compelling interest when the defendant is charged with a non-violent crime.

Like the Eighth Circuit, many of the lower courts that have considered forcible medication issues have not analyzed whether the right to bodily integrity is a fundamental right or whether the government's interest in trying the accused is compelling. Failure to conduct this analysis has resulted in a wide range of opinions regarding the types of crimes that justify forcible medication. See Brandon, 158 F.3d at 961 (finding government's interest in prosecuting individual for sending threatening mail is not compelling enough); Bee, 744 F.2d at 1395 (questioning whether the state's interest in trying suspects could ever outweigh the individual's interest in avoiding forcible treatment with antipsychotic drugs); but see Gomes, 289 F.3d at 86 (finding possession of firearm by felon serious enough to warrant forcible medication); Sell, 282 F.3d at 572-73 (stating money laundering and fraud charges justify forcible medication).[5]

The petition must be granted to confirm that the government must establish a compelling interest in trying an individual before forcibly medicating a non-violent detainee.

C. Even absent a finding of a fundamental right, the forced medication of an accused solely for prosecutorial purposes violates minimum standards of due process.

Even if this Court determines that the right to bodily integrity is not fundamental, due process still prohibits the conduct advocated by the government here. Due process requires that this Court ascertain whether the government's conduct "offend[s] those

[5] The state cases relating to forcible medication deal primarily with cases involving murder, and thus do not distinguish the state's less compelling interest in prosecuting non-violent crimes. See, e.g., Rickman v. State, 972 S.W.2d 687 (Tenn.Crim.App. 1997); Harrison v. State, 635 So.2d 894 (Miss. 1994); State v. Odiaga, 871 P.2d 801 (Idaho 1994).

canons of decency and fairness which express the notions of justice of English-speaking peoples, even those charged with [criminal] offenses." Rochin, 342 U.S. at 169.

In Rochin, police detectives required the accused to take an emetic because the police suspected that the accused had swallowed two capsules of morphine. 342 U.S. at 166. In finding that this practice violates due process, this Court stated:

> This is conduct that shocks the conscience. Illegally breaking into the privacy of the petitioner, the struggle to open his mouth and remove what was there, the forcible extraction of his stomach's contents -- this course of proceeding by agents of government to obtain evidence is bound to offend even hardened sensibilities. They are methods too close to the rack and the screw to permit of constitutional differentiation.

Id. at 172. The government here wants to permanently alter an accused's psychology and possibly alter his muscular control so that it may bring him to trial. This conduct is far more violative than the conduct found unconstitutional in Rochin. Allowing the government's prosecutorial might to extend into physical intrusions into an individual's mind violates the minimum standards of due process. Such a violation cannot be condoned in a free society.

II. The Petition Should Be Granted To Resolve The Widely Divergent Splits In Opinion Among Federal And State Courts Concerning The Standards To Be Applied When The Government Desires To Forcibly Medicate An Individual Solely For The Purpose Of Attempting To Make Him "Competent" To Stand Trial.

A. The petition should be granted to resolve a split in the lower federal courts and state courts regarding the proper standard of scrutiny.

In Riggins v. Nevada, this Court expressly recognized it has "not had occasion to develop substantive standards for judging forced administration of [antipsychotic] drugs," due to deficiencies in the Riggins record. 504 U.S. at 135. In the wake of Riggins are lower federal court and state court decisions proclaiming widely divergent standards of

scrutiny in forced medication cases.[6] This divergence means that pretrial detainees have more Constitutional protection if they are facing trial in the Sixth Circuit than if they are facing trial in the Fourth or Eighth Circuits. See Gomes, 289 F.3d at 82 (adopting heightened scrutiny standard); Sell, 282 F.3d at 567 (adopting essential state interest standard); Brandon, 158 F.3d at 957 (adopting a strict scrutiny-type standard); see also Khiem v. United States, 612 A.2d 160, 166 (D.C. 1992) (requiring overriding justification and medical appropriateness); Bee, 744 F.2d at 1395 (doubting government should ever be able to forcibly medicate individual for prosecutorial purposes alone). Given the recognized importance of an individual's right to be free from forced medication, it is imperative that the Court re-visit the issues that were left unaddressed in Riggins.

The opinions of the federal district courts and state courts also reflect a myriad of opinions regarding the standard to be applied in the forcible medication context. The federal district courts have used standards varying from strict scrutiny, to heightened scrutiny, to a hybrid balancing test requiring a compelling government interest. See United States v. Santonio, 2001 WL 670932, *5 (D. Utah May 3, 2001) (applying strict scrutiny approach), United States v. Sanchez-Hurtado, 90 F.Supp.2d 1049, 1055 (S.D. Cal. 1999) (declining to apply strict scrutiny); Woodland v. Angus, 820 F.Supp. 1497, 1505 (D. Utah 1993) (applying balancing test and finding government's interest in prosecuting a second-degree murder charge not compelling enough to overcome right to be free from forcible medication).

[6] In its Brief to the Eighth Circuit, the government stated that either a strict scrutiny or rational basis test could be applied and noted that "[t]he case law does not supply a clear answer as to which of these standards applies." See Brief of Appellee, page 20.

State court opinions provide an even more divergent view of the Constitutional standard to be applied in these cases. Although several state courts apply a heightened form of scrutiny in determining whether an individual may be forcibly medicated into competence and require that no less intrusive means exist to induce competency, other states only require a minimal showing that the medication will not affect the individual's ability to understand the proceedings against him. See State v. Garcia, 658 A.2d 947, 966-67 (Conn. 1995) (applying balancing test similar to strict scrutiny); Odiaga, 871 P.2d at 805 (using heightened scrutiny); Riggins, 860 P.2d at 705-06 (allowing forcible medication if medically appropriate, necessary to maintain competence and no less intrusive means available); State v. Lover, 707 P.2d 1351, 1353 (Wash. Ct. App. 1985) (requiring compelling state interest and finding such an interest when medication without consent of the pretrial detainee is required to make the individual competent to stand trial); State v. Law, 244 S.E.2d 302, 307 (S.C. 1978) (same); People v. Hardesty, 362 N.W.2d 787, 797 (Mich. Ct. App. 1984) (balancing state's interest in safety and trial continuity with Defendant's interest in presenting probative evidence of insanity through his manner and demeanor on witness stand). At least one state has declared that, under certain conditions, an incompetent individual may waive the right to be tried while competent. State v. Hayes, 389 A.2d 1379, 1381-82 (N.H. 1978) (finding defendant may be forcibly medicated if there are no less intrusive means to maintain competence and holding that defendant may waive his right to be tried while competent if he refuses to take medication).

The lower courts' opinions and the government's briefing in this case highlight the confusion regarding the standard to be applied in forcible medication cases. Contrary

to the express language in Riggins that the majority was not adopting a substantive standard, the Eighth Circuit erroneously concluded that the Riggins Court rejected a strict scrutiny standard of review. See Riggins, 504 U.S. at 136 (stating Court has "no occasion" to adopt a standard of strict scrutiny because of failure of district court to make findings of fact).

After improperly rejecting the strict scrutiny standard adopted by the Sixth Circuit, the District Court below appeared to outline the following test: (1) administration of antipsychotic medication is necessary to serve government's compelling interest in obtaining adjudication; (2) treatment with antipsychotic drugs is medically appropriate; and (3) drugs represent only "hope" of rendering individual competent. See United States v. Sell, No. 4:97CR290-DJS, pg. 17, App. hereto at 45 (E.D. Mo. Apr. 4, 2001) (unpublished decision). In affirming, the Eighth Circuit panel invented a new three-part test in which the government is required to (1) present an essential state interest that outweighs the individual's interest in remaining free from medication; (2) prove that there is no less intrusive way of fulfilling its interest; and (3) prove by clear and convincing evidence that medication is medically appropriate. See Sell, 282 F.3d at 567. The multiple tests applied by the lower courts and apparent confusion about this Court's holding in Riggins result in different treatment of the accused, depending on the jurisdiction in which he happens to be charged. The Court should grant the petition to clarify the applicable standard of scrutiny.

B. The petition should be granted to resolve a split in the lower federal courts and state courts regarding the proper burden of proof.

This Court has not decided the issue of the government's burden of proof when it seeks involuntary medication of a pretrial detainee. Lower court and state court decisions

on this issue require various burdens of proof, and many courts do not discuss the government's burden of proof when addressing forced medication issues. See Gomes, 289 F.3d 71, 88 (failing to discuss burden of proof); Brandon, 158 F.3d at 960-61 (requiring proof by clear and convincing evidence); Garcia, 658 A.2d at 967 (requiring proof by clear and convincing evidence); Kheim, 612 A.2d at 172 (adopting medical judgment standard).

Dr. Sell's case illustrates the confusion in the courts regarding the burden of proof to be applied. While the District Court affirmed the magistrate judge's use of a "substantial and very strong showing" standard, the Eighth Circuit required the government to prove, by clear and convincing evidence, that the medication is appropriate. See App. at 24, 45; Sell, 282 F.3d at 567-68. It is unclear what burden of proof the government is required to meet for the remaining two factors in the Eighth Circuit's three-part test.

This Court has mandated that the government prove its case by clear and convincing evidence when "the individual interests at stake in a state proceeding are both particularly important and more substantial than mere loss of money." Cruzan, 497 U.S. at 282 (citations omitted). Thus, the Court has required proof by clear and convincing evidence in deportation proceedings, Woodby v. INS, 385 U.S. 276 (1966), in denaturalization proceedings, Schnedierman v. United States, 320 U.S. 118 (1943), and in civil commitment proceedings, Addington v. Texas, 441 U.S. 418 (1979). A defendant's Constitutional right of bodily integrity should be granted equal protection with these important rights. The Court should grant the petition to determine whether the government is required to prove its case by clear and convincing evidence.

C. The facts presented do not support medication of Dr. Sell under any standard or burden of proof.

Before injecting a person with antipsychotic drugs, the government must establish, at a minimum, that the medication is necessary and appropriate. See Washington v. Harper, 494 U.S. at 222 n.8. In this case, the government was not even required to inform Dr. Sell or the district court which type of drugs or dosage it planned on injecting into him. Certainly, a showing of medical appropriateness requires that the government provide the Court and the defendant with the name of the antipsychotic drug to be administered, so that the defendant can rebut any assertions made by the government. The standardless drugging of pretrial detainees cannot comport with due process.

III. The Petition Must Be Granted To Resolve The Split Of Authority Regarding Whether The Trial Court Must Consider The Effects The Medication Will Have On Dr. Sell's Trial Rights Before Medication Is Administered.

Trial courts must be required to conduct a Sixth Amendment inquiry regarding the effects of any medication on a detainee's trial rights, prior to ordering that the detainee be involuntarily medicated. See United States v. Weston, 206 F.3d 9, 14 (D.C. Cir. 2000). Under current authority, trial courts in the District of Columbia are required to conduct a premedication review of the effects medication will have on the detainee's Sixth Amendment rights, while trial courts in the Eighth Circuit are not. See id.; Sell, 282 F.3d at 572. This dichotomy in the law results in unequal treatment of individuals entitled to equal treatment under the Constitution.

A criminal defendant's right to present his own defense is guaranteed by the compulsory process clause of the Sixth Amendment and the Fifth Amendment's guarantee that no person in a criminal case can be compelled to be a witness against

himself. See Rock v. Arkansas, 483 U.S. 44 (1987). This right is "one of the rights that are essential to due process of law in a fair adversary process." Id. at 51.

Antipsychotic medication affects the defendant's ability to assist in his defense and, in essence, forces the accused to provide the jury with a coerced confession of his mental state. See Riggins, 504 U.S. at 137, 143 (Kennedy, J., concurring); Rochin, 342 U.S. at 175 (Black, J., concurring) (finding person is compelled to be witness against himself when "incriminating evidence is forcibly taken from him by contrivance of modern science"). In a case where diminished capacity is raised as a defense, the jury must assess their belief about defendant's mental state at the time the crime occurred. "If the defendant appears calm and controlled at trial, the jury may well discount any testimony that the defendant lacked, at the time of the crime, substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law." Hardesty, 362 N.W.2d at 796 . The accused, sitting in the courtroom drugged and listless, becomes an instrument of his own conviction, with his calm and controlled demeanor rebutting his own case without a single word being uttered.

Further, compulsory medication of a defendant makes it easier for the government to rebut the accused's defense of diminished capacity by suppressing the most persuasive evidence of the individual's demeanor at the time the crime occurred. Due process does not allow the government to suppress "evidence favorable to an accused . . . where the evidence is material to either guilt or punishment." Brady v. Maryland, 373 U.S. 83, 87 (1963).

After antipsychotic drugs are administered, defendant is deprived of the best evidence of his mental state at the time of the alleged crime – his own demeanor in an

unmedicated state. Postmedication review of an individual's Sixth Amendment rights may come too late to prevent impairment of that right. See Weston, 206 F.3d at 14. "[B]oth the defendant, whose right to present a defense may be infringed by involuntary medication, and the government, whose eventual prosecution of the defendant may be foreclosed because of the infringement, are entitled to premedication resolution of the Sixth Amendment issue." Id.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

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No. 02-5664

IN THE SUPREME COURT OF THE UNITED STATES

CHARLES THOMAS SELL, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Whether the government established by clear and convincing evidence that petitioner may be treated, over his objection, with antipsychotic medication to restore his competence to stand trial.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A1-A12) is reported at 282 F.3d 560. The order of the district court (Pet. App. A29-A46) is unreported. The memorandum and order of the magistrate judge (Pet. App. A13-A28) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 7, 2002. A petition for rehearing was denied on May 7, 2002. Pet. App. A47. The petition for a writ of certiorari was filed on August 2, 2002. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. On May 16, 1997, petitioner, a dentist, was charged in a complaint with making false representations in connection with payments for health care services, in violation of 18 U.S.C. 1035(a)(2). The complaint alleged that petitioner and his wife submitted false claims, including false documents and bogus x-rays, to Medicaid and private insurance companies for dental services not provided. On May 20, 1997, the government filed a motion for a psychiatric examination of petitioner to determine his competence to stand trial, and a magistrate judge ordered that petitioner be sent to the U.S. Medical Center for Federal Prisoners at Springfield, Missouri ("Springfield"), for an evaluation. On July 15, 1997, after receiving a psychiatric evaluation from Springfield, the district court held that petitioner was competent to stand trial. Pet. App. A2-A3; Gov't C.A. Br. 3-6.

On July 30, 1997, an indictment was returned charging petitioner and his wife with 56 counts of mail fraud, in violation of 18 U.S.C. 1341; six counts of Medicaid fraud, in violation of 42 U.S.C. 1320a-7b(a)(1); and one count of money laundering, in violation of 18 U.S.C. 1957(a). Petitioner was released on bond in August 1997. Pet. App. A3; Gov't C.A. Br. 6-7.

On January 22, 1998, the government petitioned to revoke petitioner's bond, alleging that he had attempted to intimidate a witness. During an initial appearance before a magistrate judge,

petitioner screamed, shouted, and used racial epithets. When the magistrate judge tried to proceed, petitioner leaned towards her and spit directly in her face. Following a bond revocation hearing on January 26, 1998, petitioner's bond was revoked and he was detained. Pet. App. A3; Gov't C.A. Br. 7-9.

On April 23, 1998, petitioner was charged in a second indictment with conspiring to murder a witness and an FBI agent, in violation of 18 U.S.C. 1114; two counts of attempted murder of a federal witness, in violation of 18 U.S.C. 1512(a) and 1513(a); one count of attempted murder of a federal officer, in violation of 18 U.S.C. 1114; and two counts of soliciting violence, in violation of 18 U.S.C. 373. The second indictment alleged that petitioner and his wife solicited a hit man to kill a former employee at his dental office and the FBI agent who arrested him. Following a detention hearing on April 28, 1998, petitioner was detained. Over the next several months, the trial date on the two indictments was continued on a number of occasions at the request of both parties. Pet. App. A3; Gov't C.A. Br. 9-11.

2. On February 9, 1999, petitioner's counsel moved for a hearing to determine petitioner's competency to stand trial, and the government moved to have a government psychologist examine petitioner. Both petitioner's psychologist and the government psychologist diagnosed petitioner with delusional disorder, persecutory type. After a hearing on April 14, 1999, the district

court found that petitioner was suffering from a mental disease or defect that rendered him incompetent to stand trial. The court ordered that petitioner be hospitalized at Springfield for a reasonable period of time not to exceed four months to determine whether there was a substantial probability that he would attain the capacity to stand trial. Pet. App. A3; Gov't C.A. Br. 11-12.

At Springfield, petitioner was under the care of two clinicians, Dr. Richard DeMier, the clinical psychiatrist, and Dr. James Wolfson, the consulting psychiatrist, who determined that petitioner was in need of antipsychotic medication. At an administrative hearing on June 9, 1999, before a medical hearing officer, Dr. DeMier and Dr. Wolfson testified that using antipsychotic medication to treat petitioner was the only way he could be restored to competency. Petitioner proffered the affidavit of his psychiatrist, Dr. Robert Cloninger, who opined that petitioner would not respond to medication. Petitioner also called a number of witnesses and testified that he did not want to take antipsychotic medication and have his chemistry altered. Pet. App. A3-A4; Gov't C.A. Br. 12-13.

The medical hearing officer concluded that antipsychotic medication was the treatment of choice. He found that petitioner's delusional thinking could make him dangerous and that no other forms of medication or treatment could treat his delusional symptoms. Petitioner's administrative appeal was denied, but

Springfield delayed administration of the medication to give petitioner the opportunity to seek judicial review. Pet. App. A4; Gov't C.A. Br. 13.

3. At a hearing before a magistrate judge on September 29, 1999, Dr. DeMier and Dr. Wolfson testified that petitioner was in need of antipsychotic medication, that his condition would continue to deteriorate without it, that his behavior could be dangerous, and that antipsychotic medication was likely to restore him to competency. Petitioner submitted an affidavit from Dr. Cloninger, who stated that antipsychotic medication would not benefit petitioner. Dr. Cloninger recommended basic support, voluntary symptomatic treatment, and access to reading material and exercise. Pet. App. A4; Gov't C.A. Br. 14.

On August 9, 2000, the magistrate judge ordered that petitioner be involuntarily administered antipsychotic medication. Pet. App. A13-A28. He found that petitioner posed "a danger to himself and others at the institution," id. at A24, that antipsychotic medications were "the only way to render petitioner not dangerous and competent to stand trial," id. at A26, and that there were "no other less restrictive means by which this may be accomplished." Ibid.

4. The district court affirmed the magistrate judge's order. Pet. App. A29-A46. The court concluded that the magistrate judge's finding that "[petitioner] present[ed] a danger to himself or

others sufficient to constitute a compelling state interest outweighing his interest in refusing anti-psychotic medication" was "clearly erroneous." Id. at A39. The court, however, also found: "(1) that anti-psychotic drugs are medically appropriate for [petitioner], (2) that they represent the only viable hope of rendering [petitioner] competent to stand trial, and (3) that the administration of such drugs appears necessary to serve the government's compelling interest in obtaining an adjudication of [petitioner's] guilt or innocence of numerous and serious charges." Id. at A45. Based on those findings, the court concluded that "[petitioner's] substantive due process rights do not preclude the involuntary administration of anti-psychotic medication." Ibid.

5. A divided panel of the court of appeals affirmed. Pet. App. A1-A12. The court upheld the district court's ruling that the evidence did not support a finding that petitioner posed a danger to himself and others at the medical center. Id. at A5. Relying on Washington v. Harper, 494 U.S. 210 (1990), and Riggins v. Nevada, 504 U.S. 127 (1992), the court then concluded that, "subject to the limitations outlined below, the government may forcibly administer antipsychotic medication for the sole purpose of rendering a pre-trial detainee competent to stand trial without violating the accused's due process rights." Pet. App. A6.

The court of appeals rejected petitioner's claim that the district court employed the wrong standard of review to determine

whether forced administration of medication was appropriate in his case. Pet. App. A6. The court noted that this Court in Riggins declined to adopt a strict scrutiny standard, the standard urged by petitioner. Ibid. The court of appeals held:

> [T]he government must meet the following test in order for the government to forcibly medicate an individual. First, the government must present an essential state interest that outweighs the individual's interest in remaining free from medication. * * * Second, the government must prove that there is no less intrusive way of fulfilling its essential interest. * * * Third, the government must prove by clear and convincing evidence that the medication is medically appropriate. * * *

Ibid. (citations omitted). The court further explained that "[m]edication is medically appropriate if: (1) it is likely to render the patient competent * * *; (2) the likelihood and gravity of side effects do not overwhelm its benefits * * *; and (3) it is in the best medical interests of the patient." Ibid. (citations omitted).

Applying that standard, the court of appeals first concluded that "[t]he government has an essential state interest in bringing a defendant to trial." Pet. App. A7. The court noted that "[n]ot all charges, however, are sufficient to justify forcible medication of a defendant; rather, the charges must be serious." Ibid. The court decided that the 62 charges of fraud and single count of money laundering were serious enough to outweigh petitioner's

significant liberty interest in refusing antipsychotic medication. Ibid.[4]

Second, the court of appeals upheld the district court's finding that there were no less intrusive means by which the government could achieve its essential interest in bringing petitioner to trial. Pet. App. A7. The court observed that "[b]oth Dr. Wolfson and Dr. DeMier testified that antipsychotic medication [was] the most effective treatment for delusional disorder and that it [was] the only way [petitioner] could be restored to competency." Ibid. The court also noted that the affidavit from petitioner's psychologist, Dr. Cloninger, who disputed the efficacy of the medication, "did not suggest any alternative means of restoring competency." Ibid.

Third, the court of appeals upheld the district court's finding that antipsychotic medication was medically appropriate for petitioner's treatment. Pet. App. A7-A9. The court reviewed the testimony of Drs. Wolfson and DeMier and the affidavit of Dr. Cloninger, as well as a report by another psychologist submitted by petitioner. Id. at A7-A8. The court "acknowledge[d] that there [was] a difference of opinion on the efficacy of using

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[4] The court declined to consider whether the conspiracy to murder an FBI agent and a witness and the related offenses charged in the second indictment were sufficient to involuntarily medicate petitioner because "it [was] possible that [petitioner's] threats after his first indictment were a manifestation of his delusional disorder." Pet. App. A7 n.8.

antipsychotic drugs to treat delusional disorder," but the court did not believe that "the district court committed clear error in finding that the government proved medical appropriateness by clear and convincing evidence." Id. at A9. The court observed that the district court had found "a sufficient likelihood that antipsychotic medication [would] restore [petitioner's] competence," ibid., "that the side effects produced by the medication could be minimized through careful treatment and changing medications and dosages," ibid., and that the "benefits outweighed the risks associated with antipsychotic drugs." Ibid. The court of appeals accordingly concluded that "[t]he district court did not err in applying the wrong standard of review" and that "the government proved [the three required] elements by clear and convincing evidence." Ibid.

The court of appeals also found that, "before forcibly medicating an accused, there must be evidence that he will be able to participate in a fair trial." Pet. App. A9. The court found that "the medical evidence presented indicated a reasonable probability that [petitioner] will fairly be able to participate in his trial." Id. at A10. The court also noted that the district court had indicated "its willingness to re-examine [petitioner's] Sixth Amendment claim after the medication regime has begun." Ibid. The court concluded that "[t]he evidence offered, that the drugs should not interfere with [petitioner's] right to a fair

trial, as well as post-medication procedures that ensure he will not be treated unfairly, are sufficient to protect [petitioner]." Ibid.

Judge Bye dissented. Pet. App. A10-A12. He would have "appl[ied] the strict scrutiny standard of review for the reasons enunciated by the Sixth Circuit in United States v. Brandon, 158 F.3d 947, 956-961 (6th Cir. 1998)." Pet. App. A10. He also argued that the government had failed to satisfy the first part of the majority's three-part test because "the [fraud and money laundering] charges against [petitioner] are not sufficiently serious to forcibly inject him with antipsychotic drugs on the chance it will make him competent to stand trial." Ibid.

ARGUMENT

Petitioner challenges (Pet. 1-12) the determination of the courts below that petitioner may be involuntarily medicated so that he may stand trial. The lower courts' conclusion that the government had satisfied the demanding inquiry discussed in Riggins v. Nevada, 504 U.S. 127 (1992), and Washington v. Harper, 494 U.S. 210 (1990), under a clear-and-convincing burden of proof, is amply supported by the record and does not conflict with any decision of this Court or of any other court of appeals. Further review is unwarranted.

1. Although this Court has held that a person detained for trial has a constitutionally protected interest in not being

subjected to involuntary treatment with antipsychotic drugs, it has recognized that that interest may be outweighed by the State's interest in medicating an individual in appropriate circumstances. See Riggins, 504 U.S. at 135; Harper, 494 U.S. at 225-226.

In Harper, this Court held a State may treat a mentally ill prisoner with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and if the treatment is in the inmate's medical interest. 494 U.S. at 227. The Court upheld a state correctional institution's policy allowing involuntary treatment of mentally ill and dangerous prisoners with antipsychotic drugs when the State "establish[ed], by a medical finding, that a mental disorder exist[ed] which [was] likely to cause harm if not treated." Id. at 222. The policy required that medication be prescribed by one psychiatrist and approved by another, "ensur[ing] that the treatment in question will be ordered only if it is in the prisoner's medical interests, given the legitimate needs of the institutional confinement." Ibid. The Court determined that those standards, which "recognize both the prisoner's medical interests and the State's interests, meet the demands of the Due Process Clause." Id. at 222-223.

In Riggins, the Court held that "forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness." 504 U.S. at 135. The Court reversed the conviction in

that case because the state trial court had ordered that the defendant (Riggins) be administered antipsychotic drugs during his trial "without making any determination of the need for this course or any findings about reasonable alternatives." Id. at 136. The Court emphasized, however, that the State could have established an adequate justification for involuntary medication by proving that such treatment was medically appropriate and essential for the safety of Riggins or others. Id. at 135. The Court also noted that the State might have justified medically appropriate, involuntary treatment with antipsychotic drugs "by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means." Id. at 135.

The court of appeals' decision in this case comports with Harper and Riggins. The court recognized that petitioner has a significant liberty interest in avoiding forced medication. Pet. App. A5. But the court held that the government in this case had adequately justified its decision to medicate petitioner. The court noted that "[t]he government has an essential interest in bringing a defendant to trial" and concluded that, "[d]espite [petitioner's] significant liberty interest in refusing anti-psychotic medication, in view of the seriousness of the charges, * * * the government's interest in restoring his competency so that he may be brought to trial is paramount." Ibid. The court further found that there was no less intrusive means by which the

government could achieve its essential interest in bring petitioner to trial, id. at A7, and that antipsychotic medication was medically appropriate for petitioner's treatment, id. at A7-A9. Those findings do not warrant further review.

Petitioner argues that (Pet. 2-11) that the court of appeals erred in failing to determine whether he had a "fundamental" right to bodily integrity and in failing to apply strict scrutiny. This Court, however, has never held that the right of an inmate to be free from unwanted medication is "fundamental." As the court of appeals noted (Pet. App. A6), this Court made clear in Riggins that it was not "adopt[ing] a standard of strict scrutiny" to review a hospital's decision to administer forced medication to a pretrial detainee. 504 U.S. at 136; see also United States v. Gomes, 289 F.3d 71, 82 (2d Cir. 2002) (declining to adopt strict scrutiny standard as "unduly restrictive").

In any event, there is no reason to believe that a strict-scrutiny standard would produce any different outcome on the record in this case. The Court found that "[t]he government has an essential interest in bringing a defendant to trial." Pet. App. A7 (citing Illinois v. Allen, 397 U.S. 337, 347 (1970) (Brennan, J., concurring) ("Constitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and a prerequisite to social justice and peace.")). There is little question that if it had been required to find a "compelling" government interest, the

court would have done so. Moreover, the court determined that the government had established by clear and convincing evidence that antipsychotic medication would likely restore petitioner to competence to stand trial and that involuntary medication was the only way for the government to achieve that goal. Id. at A7-A9. The evidence amply supports those findings, and they are co-extensive with the tailoring requirement of strict scrutiny. Cf. United States v. Weston, 255 F.3d 873, 882-883 (D.C. Cir.), cert. denied, 122 S. Ct. 670 (2001).

Petitioner argues (Pet. 9-11) that the government's interest in bringing him to trial on charges that he committed non-violent crimes involving economic losses is not sufficiently "essential" or "compelling" to overcome his liberty interest in avoiding forced medication. In this case, however, petitioner was charged with 56 counts of health care fraud, six counts of Medicaid fraud, and one count of money laundering. The indictment alleged a pervasive scheme, orchestrated by petitioner and his wife, to submit hundreds of false claims to Medicaid and private insurance companies between 1989 and 1997. The indictment alleges that petitioner, and employees at his direction, submitted manufactured x-ray images and other altered dental records to Medicaid and private insurance companies to reflect dental problems that did not exist and dental services that were not performed. Those crimes harmed not only petitioner's patients but society at large. The court of appeals

correctly concluded that those charges were sufficiently serious to outweigh petitioner's liberty interest in avoiding forced medication. Pet. App. A7. Accord Gomes, 289 F.3d at 82 ("[W]e cannot accept the proposition that involuntary medication should be limited to defendants who are prosecuted for only the most heinous crimes."); id. at 85 (government's interest in bringing a defendant to trial is "case specific," including consideration of "whether the crime is one that is broadly harmful").[2/]

2. Petitioner claims (Pet. 12-15) that the federal circuits and state courts are in conflict over the standard governing the determination whether the government may medicate a defendant over his objection for the purpose of restoring his competency to stand trial. Pet. 24. That claim provides no basis for granting review in this case.

The court of appeals' three-part standard in this case is consistent with the "heightened scrutiny" standard applied by the District of Columbia and Second Circuits. United States v. Gomes, 289 F.3d 71, 82 (2d Cir. 2002); United States v. Weston, 255 F.3d

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[2/] Petitioner suggests (Pet. 9 n.4) that civil commitment would provide an "alternative remedy" in this case. But "even though civil commitment might reduce the danger to the community posed by an individual, it cannot address a host of other important societal concerns and values served by a criminal trial: 'the retributive, deterrent, communicative and investigative functions of the criminal justice system * * * serve to ensure that offenders receive their just deserts, to make clear that offenses entail consequences, and to discover what happened through the public mechanism of trial.'" Gomes, 289 F.3d at 81 (quoting Weston, 255 F.3d at 882).

873, 880 (D.C. Cir.), cert. denied, 122 S. Ct. 670 (2001). Petitioner claims (Pet. 7, 13), though, that the decision in this case conflicts with the strict scrutiny standard adopted by the Sixth Circuit in United States v. Brandon, 158 F.3d 947, 960 (6th Cir. 1998). Although the Sixth Circuit in Brandon and the Eighth Circuit in this case characterized the governing analysis differently, the two decisions are not in direct conflict because the three-part standard applied by the Eighth Circuit is functionally equivalent to the inquiry conducted by the Sixth Circuit in Brandon.

Under its "strict scrutiny" approach, the Brandon court required the government to prove a "compelling" state interest, Brandon, 158 F.3d at 961, while under its three-part standard the Eighth Circuit required the government to show an "essential" interest, Pet. App. A6. Both courts considered whether the antipsychotic medication was "medically appropriate" and whether "less intrusive alternatives" to antipsychotic medication existed. Brandon, 158 F.3d at 960; Pet. App. A6, A9. Both courts assessed the impact that antipsychotic medication could have on the defendant's fair trial rights. Brandon, 158 F.3d at 960; Pet. App. A9-A10. And both courts recognized that the defendant's interest in avoiding unwanted medication was significant, but not absolute. Brandon, 158 F.3d at 953-954; Pet. App. A5.

The other federal court of appeals decision on which petitioner relies (Pet. 13) in attempting to establish a conflict, Bee v. Greaves, 744 F.2d 1387 (10th Cir. 1984), cert. denied, 469 U.S. 1214 (1985), does not further his claim. Bee was decided before this Court's decisions in Harper and Riggins. In addition, the Bee court stated that the involuntary administration of antipsychotic medication to a pretrial detainee could not be justified on the ground that such treatment was necessary to maintain the detainee's competence, since the detainee in that case had already been found competent to stand trial. Bee, 744 F.2d at 1395. By contrast, the courts below found that petitioner is incompetent to stand trial, and that that is unlikely to change in the absence of the challenged medication.[3/]

Nor do the state court decisions cited by petitioner support his claim of a direct conflict with the decision below. Four of the cases -- People v. Hardesty, 362 N.W.2d 787 (Mich. Ct. App. 1984); State v. Lover, 707 P.2d 1351 (Wash. Ct. App. 1985); State v. Hayes, 389 A.2d 1379 (N.H. 1978), and State v. Law, 244 S.E.2d

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[3/] Petitioner's reliance on district court cases to establish a conflict is equally unavailing. Those cases applied either a strict scrutiny standard (United States v. Santonio, 2001 WL 670932 (D. Utah May 3, 2001), and Woodland v. Angus, 820 F.Supp. 1497 (D. Utah 1993)), or a standard derived from Riggins and similar to that applied below (see United States v. Sanchez-Hurtado, 90 F.Supp.2d 1049 (S.C. Cal. 1999)). For the reasons discussed above (at 16), those approaches are not in direct conflict.

302 (S. Car. 1978) -- were decided long before Harper and Riggins.[1] State v. Odiaga, 871 P.2d 801 (Idaho), cert. denied, 513 U.S. 952 (1994), was remanded so that the trial court could reconsider its opinion in light of Riggins. In the other cases cited by petitioner -- State v. Garcia, 658 A.2d 947 (Conn. 1995), and Khiem v. United States, 612 A.2d 160 (App. D.C. 1992), cert. denied, 507 U.S. 924 (1993) -- the courts recognized, as did the court below, that the State may involuntarily medicate a defendant if the administration of the drugs is "medically appropriate," and the state demonstrates an overriding justification for doing so. Garcia, 658 A.2d at 964; Khiem, 612 A.2d at 165-166.

Furthermore, even if the asserted conflict were real, this case would be an ill-suited vehicle for resolving it. The extensive record developed in this case satisfies the strict scrutiny standard espoused by petitioner. See pp. 13-14, supra. On the record before this Court, the government has demonstrated that treating petitioner with antipsychotic drugs will not deprive him of his due process rights, regardless of the applicable standard of scrutiny.

3. Petitioner also asserts (Pet. 15-16) a conflict among the circuits and the state courts of highest resort on the standard of proof that the government must meet to justify administering forced

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[1] In addition, Hardesty and Lover were decisions by intermediate appellate courts, not state courts of last resort.

medication. That contention provides no basis for review. Petitioner asserts (Pet. 16) that the government should be required to satisfy the clear-and-convincing evidence standard. The court of appeals concluded, however, that the government proved the elements of the three-part test "by clear and convincing evidence" in this case. Pet. App. A9.

In any event, where, as here, courts have required a judicial hearing to determine whether medication should be administered to an inmate solely to restore competence, they have ruled that the government must meet its burden by "clear and convincing" evidence. See Brandon, 158 F.3d at 961; Sanchez-Hurtado, 90 F.Supp.2d at 1055; Garcia, 658 A.2d at 967. The government has not challenged the application of that standard in this case. And petitioner identifies no cases in which a court has applied a lesser standard at a judicial hearing. One case cited by petitioner (Pet. 16) dealt with the separate question of whether due process is met when medical professionals initially decide whether antipsychotic medication is medically necessary, and whether the courts should apply a deferential standard of review to that decision. See Khiem, 612 A.2d at 171-172. Because that question is not implicated by the facts of this case, and because the court below applied the standard that petitioner advocates, further review is unnecessary.

4. Finally, petitioner asserts (Pet. 17-19) a conflict among the circuits on whether courts must determine whether administering antipsychotic medication would adversely affect a defendant's trial rights. Petitioner's claim rests on the premise that the courts below did not conduct a pre-medication analysis of whether petitioner's trial rights would be prejudiced. The record belies that claim. In addressing petitioner's Sixth Amendment claim, the court of appeals recognized that "before forcibly medicating an accused, there must be evidence that he will be able to participate in a fair trial," Pet. App. A9, and the court concluded that "[t]hat burden was met in this case." Id. at A10. That analysis is the same type of pre-medication analysis of a defendant's trial rights as has been conducted by the other courts of appeals. Gomes, 289 F.3d at 82-84; Weston, 255 F.3d at 883-885; Brandon, 158 F.3d at 960. Indeed, in concluding that forced medication would not prejudice petitioner's right to a fair trial, the court below specifically cited Brandon. Pet. App. A9-A10. Accordingly, petitioner's claim warrants no further review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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OCTOBER 2002

No. 02-5664 (4)

DEC 17 2002

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In The
Supreme Court of the United States

CHARLES THOMAS SELL, D.D.S.,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX
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May 16, 1997	Complaint Against Charles Thomas Sell, D.D.S. Signed, Cause No. 97CR290.
May 16, 1997	Charles Thomas Sell, D.D.S. Arrested and Detained.
May 20, 1997	Motion for Psychiatric Examination of Charles Thomas Sell, D.D.S. Filed by USA.
May 20, 1997	Motion for Psychiatric Examination of Charles Thomas Sell, D.D.S. Granted.
July 2, 1997	Report of Psychiatric Evaluation of Charles Thomas Sell, D.D.S. Filed.
July 15, 1997	Preliminary Examination and Detention Hearing Held; Testimony Presented; Charles Thomas Sell, D.D.S. Found Competent to Stand Trial.
July 30, 1997	Five Count Indictment of Charles Thomas Sell, D.D.S. Filed by USA, Cause No. 97CR290.
August 27, 1997	Conditions of Release of Charles Thomas Sell, D.D.S. Ordered; Bond Posted by Charles Thomas Sell.
November 6, 1997	Sixty-Three Count Superseding Indictment of Charles Thomas Sell, D.D.S. Filed by USA, Cause No. 97CR290.
January 22, 1998	Petition for Action on Conditions of Pretrial Release Filed by USA.

January 23, 1998	Charles Thomas Sell, D.D.S. Arrested.
January 29, 1998	Petition for Action on Conditions of Pretrial Release Granted; Bond Revoked; Detention of Charles Thomas Sell, D.D.S. Ordered.
April 23, 1998	Six Count Indictment of Charles Thomas Sell, D.D.S. Filed by USA, Cause No. 98CR177.
May 22, 1998	Cause No. 97CR290 and Cause No. 98CR177 Consolidated.
October 14, 1998	Notice of Intent to Introduce Evidence of Mental Disease or Defect Filed by Charles Thomas Sell, D.D.S.
October 15, 1998	Motion for Psychiatric Examination Filed by USA.
November 25, 1998	Motion for Psychiatric Examination to Determine Charles Thomas Sell, D.D.S.'s Mental Competency to Stand Trial Denied; Motion for Psychiatric Examination to Determine Charles Thomas Sell, D.D.S.'s Mental Competency on the Date of the Alleged Offenses Granted.
February 10, 1999	Motion for Hearing to Determine Charles Thomas Sell, D.D.S.'s Competency Filed by Charles Thomas Sell, D.D.S.
February 16, 1999	Motion for Psychiatric Examination to Determine Charles Thomas Sell, D.D.S.'s Competency Filed by USA.

February 22, 1999	Motion for Psychiatric Examination to determine Charles Thomas Sell, D.D.S.'s Competency Granted.
April 12, 1999	Report of Psychiatric Evaluation of Charles Thomas Sell, D.D.S. Filed.
April 14, 1999	Hospitalization and Evaluation of Charles Thomas Sell, D.D.S. for a Period of Time Not to Exceed Four Months to Determine Whether There is a Substantial Probability that, in the Foreseeable Future, Charles Thomas Sell, D.D.S. will Attain the Capacity to Proceed to Trial.
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July 30, 1999	Motion for Judicial Determination Regarding Involuntary Psychiatric Treatment and Medication Filed by Charles Thomas Sell, D.D.S.
August 20, 1999	Response to Motion for Judicial Determination Regarding Involuntary Psychiatric Treatment and Medication Filed by USA.
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	Involuntary Psychiatric Treatment and Medication Held.
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January 24, 2000	Post-Hearing Memorandum in Opposition to Involuntary Medication Filed by Charles Thomas Sell, D.D.S.
February 24, 2000	Response to Post-Hearing Memorandum in Support of Involuntary Medication Filed by Charles Thomas Sell, D.D.S.
March 20, 2000	Report of Psychiatric Evaluation of Charles Thomas Sell, D.D.S. Filed.
August 9, 2000	Involuntary Medication of Charles Thomas Sell, D.D.S. Ordered by United States Magistrate Judge.
August 17, 2000	Motion for Reconsideration of the August 9, 2000 Order Permitting the Involuntary Medication of Charles Thomas Sell, D.D.S., to Reopen the September 29, 1999 Evidentiary Hearing Concerning the Involuntary Medication of Charles Thomas Sell, D.D.S., and to Compel the Production of Evidence of the Physical Abuse of Charles Thomas Sell, D.D.S. While Housed Pending Trial.
August 18, 2000	Motion for United State Magistrate Judge to Reconsider the August 9, 2000 Order Permitting the Involuntary Medication of Charles Thomas

	Sell, D.D.S., to Reopen the September 29, 1999 Evidentiary Hearing Concerning the Involuntary Medication of Charles Thomas Sell, D.D.S., and to Compel the Production of Evidence of the Physical Abuse of Charles Thomas Sell, D.D.S. While Housed Pending Trial Denied by United States Magistrate Judge.
August 22, 2000	Motion for United States District Court to Reconsider United States Magistrate Judge's Ruling Concerning Involuntary Medication of Charles Thomas Sell, D.D.S.
November 1, 2000	Response to Motion to Reconsider Filed by USA.
November 8, 2000	Reply to Motion to Reconsider Filed by Charles Thomas Sell, D.D.S.
December 20, 2000	Update to Reply to Motion to Reconsider Filed by Charles Thomas Sell, D.D.S.
January 5, 2001	Second Update to Reply to Motion to Reconsider Filed by Charles Thomas Sell, D.D.S.
April 4, 2001	Motion to Reconsider Order Permitting Involuntary Medication of Charles Thomas Sell, D.D.S. Denied by the United States District Court.
April 13, 2001	Notice of Appeal to the United States Court of Appeals for the Eighth Circuit Concerning Involuntary Medication Filed by Charles Thomas Sell, D.D.S.

October 15, 2001	Argued and Submitted to the United States Court of Appeals for the Eighth Circuit, Judges Pasco M. Bowman, Gerald W. Heaney, and Kermit E. Bye.
March 7, 2002	Involuntary Medication of Charles Thomas Sell, D.D.S. Affirmed by the United States Court of Appeals for the Eighth Circuit, *United States v. Sell*, 282 F.3d 560 (8th Cir. 2002) (2-1 decision) (Bye, J., dissenting).
April 8, 2002	Amended Petition for Rehearing and Petition for Rehearing *En Banc* Filed by Charles Thomas Sell, D.D.S.
April 22, 2002	Response to Amended Petition for Rehearing and Petition for Rehearing *En Banc* Filed by USA.
May 7, 2002	Petition for Rehearing and Petition for Rehearing *En Banc* Denied by United States Court of Appeals for the Eighth Circuit, *United States v. Sell,* 282 F.3d 560 (8th Cir. 2002) (5-4 decision) (Loken, J., Murphy, J., Bye, J., and Riley, J voted to grant the petition for rehearing *en banc*) (McMillian, J. took no part).
August 2, 2002	Notice of Petition for *Writ of Certiorari* Concerning Involuntary Medication Filed by Charles Thomas Sell, D.D.S.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. DR. CHARLES THOMAS SELL, D.D.S. and MARY SELL, Defendants.	No. 4 97 CR00290DJS (Filed July 30, 1997)

INDICTMENT

BACKGROUND

The Grand Jury charges that at all times material to this indictment:

1. Charles Thomas Sell, the defendant herein, was a dentist practicing dentistry in St. Louis County, Missouri.

2. Mary Sell, the defendant herein, was the office manager for Dr. Charles T. Sell.

3. The defendants directed their employees to place information in claim forms which they knew was false.

4. The Missouri Medicaid Program (Medicaid) was jointly funded by both the federal government and the State of Missouri and was a state health care program as defined in Title 42, United States Code, Section

1320a-7(h). The Department of Social Services, Division of Medical Services (hereafter referred to as DMS) administered the Medicaid program in Missouri.

5. Medicaid paid the cost of certain health care expenses for qualified individuals – Medicaid recipients.

6. DMS contracted with GTE data services (hereafter referred to as GTE), to serve as its fiscal agent to handle the receipt and processing of Medicaid claims in Missouri. The claims were received and processed in Jefferson City, Missouri.

7. Upon application by a health care provider and approval by DMS, DMS assigned provider numbers to various health care providers, including dentists. The provider number allowed the health care provider to bill Medicaid directly for services rendered by the enrolled provider to patients who were eligible and received medical services under the Medicaid program.

8. Enrolled providers agreed to abide by Medicaid policies and procedures. Medicaid policy, with respect to dentists, required that the enrolled provider only bill for the services actually performed by the provider.

9. An authorized provider of dental services was reimbursed for furnishing dental services to Medicaid recipients upon submission of an application for payment to the Medicaid program.

10. Payment for dental services billed on an application are determined in part, by procedure codes. Procedure codes are numbers which are placed on the application for payment and identify a specific dental service.

COUNTS I-IV

The Grand Jury charges that:

11. On or about the dates set forth hereinafter, in the Eastern District of Missouri,

CHARLES THOMAS SELL and MARY SELL,

the defendants, herein, knowingly and willfully made, and caused to be made, false statements and representations of material facts on the applications for payment of Medicaid funds for dental service in that the defendants, Charles Thomas Sell and Mary Sell, stated and represented that Charles Thomas Sell had performed specific services, identified in part by procedure code numbers, on the dates indicated and that the defendants herein then and there well knew said statements and representations on the applications for payment were false, in that Dr. Sell had not provided the dental services as described and identified by the procedure code numbers.

Count	Patient	Date of Service	False Procedure Code on Claim
1.	Nancy R.	6-14-96	D2331
2.	Cynthia J.	12-29-95	D2331
3.	Cynthia J.	5-24-96	D2331
4.	Cynthia J.	12-13-96	D2331

All in violation of Title 42, United States Code, Section 1320a-7b(a)(1)(i).

COUNT V

Paragraphs 1-3, as set out above, are incorporated herein.

12. American Medical Security is a private health care benefit program as defined in Section 341 of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

13. American Medical Security reimbursed providers for certain services provided to persons insured by American Medical Security. American Medical Security required that the provider bill only for those services actually provided to the insured.

COUNT V

The Grand Jury further charges that:

14. On or about January 4, 1997, in the Eastern district of Missouri, in a matter involving a health care benefit program, the defendants,

CHARLES THOMAS SELL and MARY SELL

knowingly and willfully made or caused to be made a materially false document, knowing the same to contain a false and fraudulent material statement, in that the defendants knew that the claim form submitted to American Medical Security falsely and fraudulently represented that the defendant Dr. Charles Sell had placed 16 composite resin filings, identified by procedure code D2331, in the teeth of patient James M. on January 4, 1997.

All in violation of Title 18, United States Code, Section 1035(a)(2).

A TRUE BILL

/s/ Janet Horchner
FOREPERSON

EDWARD L. DOWD, JR.
United States Attorney

/s/ Dorothy McMurtry
DOROTHY L. McMURTRY
Assistant United States Attorney

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA,	)	
Plaintiff,	)	
	)	No. S1-4:97CR290
v.	)	DJS/Term
DR. CHARLES THOMAS SELL, D.D.S. and MARY SELL,	)	(Filed Nov. 6, 1997)
Defendants.	)	

INDICTMENT

BACKGROUND

The Grand Jury charges that at all times material to this indictment:

1. Dr. Charles Thomas Sell, D.D.S., the defendant herein, was a dentist practicing dentistry in St. Louis County, Missouri.

2. Mary Sell, the defendant herein, was the wife of and office manager for defendant Dr. Sell.

Medicaid

3. The Missouri Medicaid Program (Medicaid) was jointly funded by both the federal government and the State of Missouri and was a state health care program as defined in Title 42, United States Code, Section 1320a-7(h). The Department of Social Services, Division of Medical Services (hereafter referred to as DMS), administered the Medicaid program in Missouri.

4. Medicaid paid the cost of certain health care expenses for qualified individuals, referred to on occasion as Medicaid recipients.

5. DMS contracted with GTE data services (hereafter referred to as GTE), to serve as its fiscal agent and to handle the receipt and processing of Medicaid claims in Missouri. The claims were received and processed in Jefferson City, Missouri.

6. Upon application by a health care provider and approval by DMS, DMS assigned provider numbers to various health care providers, including dentists. The provider number allowed the health care provider to bill Medicaid directly for services rendered by the enrolled provider to Medicaid recipients, who had received medical services under the Medicaid program.

7. Enrolled providers agreed to abide by Medicaid policies and procedures. Medicaid policy, with respect to dentists, required that the enrolled provider only bill for the services actually performed by the provider.

8. To obtain reimbursement, authorized providers were required to submit an application for payment, or a claim form, to the Medicaid program. Payments for dental services billed on an application or claim form were determined, in part, by procedure codes. Procedure codes are numbers that are placed on the application for payment or claim form and identify a specific dental service.

Private Insurance Companies

9. Aetna, American Commercial Terminal, American Medical Security, Blue Cross/Blue Shield, Delta Dental, Provident Life & Accident, Prudential, and Western Union

(hereafter referred to collectively as Private Insurers) were private health care benefit programs or insurance companies, that reimbursed providers for specified services rendered to persons insured by their respective companies. These Private Insurers only paid for those services actually provided to the insured patient.

10. To obtain reimbursement, authorized providers were required to submit an application for payment, or a claim form, to the Private Insurers. Payments for dental services were determined, in part, by procedure codes. Procedure codes are numbers that are placed on the application for payment or claim form and identify a specific dental service.

COUNTS 1-56

(MAIL FRAUD 18 U.S.C. § 1341)

The Grand Jury realleges, and incorporates by reference, the allegations in paragraphs 1 through 10 of this indictment and further alleges:

THE SCHEME TO DEFRAUD

11. It was the purpose of the scheme that the defendants would obtain money and property by means of false or fraudulent pretenses, representations, or promises. As part of the scheme, the defendants, and their employees at their direction, submitted false or fraudulent claims to Medicaid and Private Insurers to obtain payments for dental services which they knew defendant Dr. Sell had not rendered.

12. It was further part of the scheme that the defendants, and their employees at their direction, created and

maintained patient files which reflected services which had not been rendered.

13. It was further part of the scheme that the defendants, and their employees at their direction, provided false and fraudulent information, to Medicaid and Private Insurers, when Medicaid or Private Insurers asked for justification for the claims submitted by the defendants.

14. It was further part of the scheme that the defendants altered x-rays to justify resin and amalgam fillings that defendant Dr. Sell had not provided, but for which the defendants billed Medicaid and Private Insurers.

15. It was further part of the scheme that the defendants, and their employees at their direction, submitted the x-rays of one patient to justify services provided to another patient.

16. It was further part of the scheme that the defendants, and their employees at their direction, routinely "maxed out" the insurance policies of patients within a short period of time by billing for services that defendant Dr. Sell did not render.

17. It was further part of the scheme that the defendants, and their employees at their direction, billed Medicaid and the Private Insurers for covered or reimbursable services when defendant Dr. Sell had actually provided a service that was not covered or was covered at a lower rate of reimbursement.

18. It was further part of the scheme that the defendants, and their employees at their direction, submitted, or caused to be submitted, questionnaires, that had been sent to patients by the Private Insurers to verify that defendant Dr. Sell had provided dental services to the

patients. The defendants knew that the information contained in the questionnaires was false at the time the questionnaires were submitted.

19. It was further part of the scheme that the defendants submitted, or caused to be submitted, to the Private Insurers, letters, that the defendants knew falsely and fraudulently represented that defendant Dr. Sell had provided dental services.

20. It was further part of the scheme that the defendants routinely waived co-payments from the patients of defendant Dr. Sell and concealed this fact from the Private Insurers.

MAILINGS IN FURTHERANCE OF THE SCHEME

21. It was further part of the scheme that the defendants, and their employees at their direction, used the United States mail for a variety of purposes, including submitting claims to Medicaid and the Private Insurers, receiving payments from Medicaid and the Private Insurers, and sending and receiving correspondence from Medicaid, Private Insurers, and patients.

22. Beginning in 1989 and continuing through May 1997, the exact dates being unknown to the Grand Jury, in the Eastern District of Missouri and elsewhere, the defendants,

CHARLES THOMAS SELL and MARY SELL,

and other persons known and unknown to the Grand Jury, having devised the above described scheme and artifice, for the purpose of executing and attempting to execute the above described scheme and artifice to defraud, and for the

purpose of obtaining money and property from Medicaid and the Private Insurers by means of false and fraudulent pretenses, representations, and promises, did knowingly place and cause to be placed in a post office or authorized depository for mail matter, things or matters to be sent or delivered by the postal service and then did take and receive therefrom, the following matter or things, and knowingly caused to be delivered by directions thereon claim forms and applications for payments:

Count	Patient	Date of Service	False Procedure Code on Claim
AETNA			
1.	Melvin W.	5/26/94	2331, 2332
AMERICAN COMMERCIAL TERMINAL			
2.	Jessica V.	12/31/93	2331, 2330
3.	Jessica V.	11/29/96	2330, 2331
AMERICAN MEDICAL SECURITY			
4.	Sharon E.	12/10/96	2150, 2160
5.	Sharon E.	12/17/96	2150, 2160
6.	Orville E.	12/19/96	2160, 2150
7.	Orville E.	12/23/96	2332, 2335
8.	Dmitry K.	12/23/96	2150
9.	Dmitry K.	3/27/97	2335
10.	Mato L.	10/1/96	2160, 2161, 2150
11.	Mato L.	10/15/96	2160, 2140
12.	James M.	1/4/97	2331, 2330
13.	James M.	1/15/96	2335

14.	Celine W.	11/22/96	2160
15.	Darren W.	10/29/96	2335, 9951
16.	Darren W.	11/5/96	2335
17.	Darren W.	11/12/96	2335
18.	Darren W.	11/19/96	2335
19.	Timmy W.	11/4/96	2331
20.	Timmy W.	11/11/96	2331, 2330
21.	Timmy W.	11/18/96	2331
22.	Timmy W.	11/29/96	2331, 2332, 2335

BLUE CROSS/BLUE SHIELD

23.	Celine W.	11/26/96	2160
24.	Darren W.	12/21/96	2335
25.	Timmy W.	11/29/96	2331, 2332

DELTA

26.	Scott B.	9/24/94	2330, 2331
27.	Scott B.	4/3/95	2331
28.	Scott B.	3/7/96	2331, 2330
29.	Allison B.	4/2/94	2330
30.	Laura B.	8/3/94	2330
31.	Laura B.	3/7/96	2330, 2331
32.	Laura B.	11/23/96	2335
33.	Laura B.	2/22/97	2330
34.	Betty L.	10/22/96	2335, 2332, 2331, 2330
35.	David L.	12/22/95	2330, 2331, 2335

36.	David L.	10/23/96	2330, 2331, 2335
37.	Jason L.	3/27/95	2330, 2331, 2332
38.	Nicole L.	8/1/94	2330, 2150
39.	Nicole L.	12/22/95	2335
40.	Nicole L.	6/22/93	2330
41.	Frank S.	1/18/93	2335
42.	Frank S.	12/20/93	2330, 2332, 2331
43.	Frank S.	1/5/95	2332, 2335
44.	Lynne T.	8/9/94	2330, 2331, 2332
45.	Lynne T.	12/2/95	2335

MEDICAID

46.	Cynthia J.	12/29/95	D2331
47.	Cynthia J.	5/24/96	D2331
48.	Cynthia J.	12/13/96	D2331

METROPOLITAN LIFE

49.	Mary Ann S.	1-13-94	2335, 2332
50.	Mary Ann S.	1-22-96	2335

PROVIDENT LIFE AND ACCIDENT

51.	Shaun R.	12/29/95	2330
52.	Shaun R.	11/15/96	2330

PRUDENTIAL

53.	Kim C.	2/25/97	2332, 2335
54.	David R.	5/9/95	2330

WESTERN UNION			
55.	Faye A.	12/4/93	2335, 2330, 2331, 2332
56.	Faye A.	1/31/95	2330, 2331

All in violation of Title 18, United States Code, Section 1341.

COUNTS 57-62

(MEDICAID FRAUD 42 U.S.C. § 1320a-7b(a)(1)(i))

The Grand Jury charges that:

23. On or about the dates set forth hereinafter, in the Eastern District of Missouri,

CHARLES THOMAS SELL and MARY SELL,

the defendants, herein, knowingly and willfully made, and caused to be made, false statements and representations of material facts on the applications for payment of Medicaid funds for dental service in that the defendants, Charles Thomas Sell and Mary Sell, stated and represented that Charles Thomas Sell had performed specific services, identified in part by procedure code numbers, on the dates indicated and that the defendants herein then and there well knew said statements and representations on the applications for payment were false, in that Dr. Sell had not provided the dental services as described and identified by the procedure code numbers.

Count	Patient	Date of Service	False Procedure Code on Claim
57.	Charlene A.	8/11/95	D2331
58.	Carolyn A.	2/23/96	D2331

59.	Christine C.	5/19/95	D2160, D2331
60.	Dana M.	11/29/96	D2331
61.	Dana M.	11/29/96	D2331
62.	Nancy R.	6/14/96	D2331

All in violation of Title 42, United States Code, Section 1320a-7b(a)(1)(i).

COUNT 63

(MONEY LAUNDERING 18 U.S.C. § 1957(a))

The Grand Jury realleges, and incorporates by reference, the allegations in paragraphs 1 through 20 of this indictment and further alleges:

24. On or about April 15, 1997, in the Eastern District of Missouri,

CHARLES THOMAS SELL and MARY SELL,

did knowingly engage and attempt to engage in a monetary transaction by, through, or to a financial institution, affecting interstate and foreign commerce, in a criminally derived property of a value greater than $10,000.00, that is, a deposit of funds in the amount of $21,202.00 into an account at A.G. Edwards and Sons, Inc., which account is identified as account number 98-493514-260, and "A.G. Edwards and Sons, D16, C/F C. Thomas Sell, D.D.S., FBO C. Thomas Sell Profit Sharing Plan", such property having been derived from a specified unlawful activity, that is, mail fraud.

In violation of Title 18, U.S.C. Section 1957(a).

A TRUE BILL

/s/ [Illegible]
FOREPERSON

EDWARD L. DOWD, JR.
United States Attorney

/s/ Dorothy L. McMurtry
DOROTHY L. McMURTRY
Assistant United States Attorney

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA,	)	
Plaintiff,	)	
v.	)	**No.**
CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL,	)	
Defendants.	)	

INDICTMENT

COUNT I

The Grand Jury charges that:

Beginning in or about December 1997, and continuing until March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, did knowingly and wilfully combine, conspire, confederate and agree with each other to kill Jane Alderman with the intent to prevent the attendance and testimony of Jane Alderman in an official proceeding, and with intent to retaliate against Jane Alderman for providing to a law enforcement officer information relating to the commission and possible commission of a Federal offense; said actions constituting violations of Title 18, United States Code, Sections 1512 and 1513; and to kill Federal Bureau of Investigation Special Agent Anthony Box, an officer or employee of the United States, on account of and while in the performance

of his official duties, said actions constituting violations of Title 18, United States Code, Section 1114.

THE CONSPIRACY

The object and purpose of the conspiracy were as follows:

1. **CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL** intended to prevent the attendance and testimony of Jane Alderman at trial proceedings against **CHARLES T. SELL and MARY SELL** in the United States District Court for the Eastern District of Missouri. The caption in that case is *United States v. Sell*, S1 4:97CR290 DJS.

2. **CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL** intended to retaliate against Jane Alderman for providing information to law enforcement officials in the investigation of **CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL** for violations of federal law.

3. **CHARLES T. SELL, a/k/a TOM SELL,** directed that Jane Alderman be killed.

4. **MARY SELL** provided an associate with Jane Alderman's home address, social security number and a description of Jane Alderman's vehicle.

5. **MARY SELL** provided an associate with currency with which he was to pay a hit man as a partial down payment for the murder of Jane Alderman and Federal Bureau of Investigation Special Agent Anthony Box.

6. **CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL** intended to retaliate against Federal

Bureau of Investigation Special Agent Anthony Box for the arrest of **CHARLES T. SELL, a/k/a TOM SELL.**

7. **CHARLES T. SELL, a/k/a TOM SELL,** referred to Special Agent Anthony Box, an African-American, in racially derogatory terms and directed that he be killed.

OVERT ACTS

In furtherance of the conspiracy, and to effect the objects thereof, the defendants committed or caused the commission of the following overt acts:

1. In or about December, 1997, **CHARLES T. SELL, a/k/a TOM SELL,** loaned Jonathan Gamble $500 with which to purchase a pistol.

2. In or about December 1997, **CHARLES T. SELL, a/k/a TOM SELL,** directed that Jonathan Gamble murder or arrange the murders of Federal Bureau of Investigation Special Agent Anthony Box, Special Agent Sal Hernandez and Special Agent Kevin Cosentino.

3. In or about January 1998, **CHARLES T. SELL, a/k/a TOM SELL,** directed that Jonathan Gamble murder or arrange the murder of Jane Alderman.

4. On or about February 6, 1998, **MARY SELL** met with Jonathan Gamble and advised him that she wanted Jane Alderman dead and that **CHARLES T. SELL, a/k/a TOM SELL,** wanted Special Agent Anthony Box dead.

5. On or about February 12, 1998, **MARY SELL** told Jonathan Gamble that it was not "cool" for an associate of theirs to talk on the telephone about locating the residence of Special Agent Anthony Box.

6. On or about February 20, 1998, **MARY SELL** frisked Jonathan Gamble to determine if he was wearing a wire.

7. On or about February 20, 1998, **MARY SELL** met Jonathan Gamble and gave him $235 as a partial down payment for another person to murder Jane Alderman and Special Agent Anthony Box.

8. On or about March 4, 1998, Jonathan Gamble met with **CHARLES T. SELL, a/k/a TOM SELL,** who advised Jonathan Gamble "you're gonna have to do this, what, what you would think I would want, . . . there's no way I can say . . . " and "Well, I'll tell you what, I'll tell you what, heres, if you're gonna do it . . . go for the big guy, man."; "For the, for the A.B., okay?"; "Aryan Brotherhood, man."

All in violation of Title 18, United States Code, Section 371.

COUNT II

The Grand Jury further charges that:

Between in or about December 1997, and continuing until March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, did knowingly and wilfully attempt to kill Jane Alderman, with intent to prevent the attendance and testimony of Jane Alderman in an official proceeding, that is, the trial of federal criminal charges pending against **CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL** in the United States District Court for

the Eastern District of Missouri, under the caption *United States v. Sell*, S1 4:97CR290 DJS, and the defendants committed a substantial step in furtherance of that attempt.

In violation of Title 18, United States Code, Sections 2 and 1512(a)(1)(A).

COUNT III

The Grand Jury further charges that:

Between in or about December 1997, and continuing until March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, did knowingly and wilfully attempt to kill Jane Alderman, with intent to retaliate against Jane Alderman for providing to a law enforcement officer any information relating to the commission and possible commission of a Federal offense, and the defendants committed a substantial step in furtherance of that attempt.

In violation of Title 18, United States Code, Section 2 and 1513(a)(1)(B).

COUNT IV

The Grand Jury further charges that:

Between December 1997, and March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, did knowingly and wilfully attempt to kill Federal Bureau of Investigation Special Agent Anthony Box, an employee and officer of the United States, while Special Agent Anthony Box was engaged in and on account of the performance of his official duties, and the defendants committed a substantial step in furtherance of that attempt.

In violation of Title 18, United States Code, Sections 2 and 1114.

COUNT V

The Grand Jury further charges that:

Between in or about December, 1997 and March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, with intent that Jonathan Gamble engage in conduct constituting a felony that has as an element the use of physical force against the person of another in violation of the laws of the United States and under circumstances strongly corroborative of the intent, did solicit, command, induce and endeavor to persuade Jonathan Gamble to engage in such conduct, that is, the murder of Federal Bureau of Investigation Special Agent Anthony Box, an officer of the United States in violation of Title 18, United States Code, §1114.

In violation of Title 18, United States Code, Sections 2 and 373.

COUNT VI

The Grand Jury further charges that:

Between in or about December, 1997 and March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, with intent that Jonathan Gamble engage in conduct constituting a felony that has as an element the use of physical force against the person of another in violation of the laws of the United States and under circumstances strongly corroborative of the intent, did solicit, command, induce and endeavor to persuade Jonathan Gamble to engage in such conduct, that is the murder of Jane Alderman, a witness in violation of Title 18, United States Code, Sections 1512 and 1513.

In violation of Title 18, United States Code, Sections 2 and 373.

A TRUE BILL.

_____
FOREPERSON

EDWARD L. DOWD, JR.
United States Attorney

_____
HOWARD J. MARCUS #16980
Assistant United States Attorney

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF C. ROBERT CLONINGER, M.D.

C. ROBERT CLONINGER, M.D., being first duly sworn upon his oath, states:

1. I am over 21 years of age; I have personal knowledge of and am competent to testify to the matters set forth in this Affidavit.

2. I am the Wallace Renard Professor of Psychiatry & Genetics at Washington University School of Medicine in St. Louis and the Director of the Center of Psychobiology of Personality at Washington University School of Medicine in St. Louis. A copy of my *curriculum vitae* is attached as *Exhibit A*.

3. This Affidavit reflects my expert opinion as a psychiatrist regarding the treatment of Dr. Charles Thomas Sell who is diagnosed as having Delusional Disorder.

4. Unlike Schizophrenia, Delusional Disorder is a rare condition, so few psychiatrists have extensive experience with this.

5. The basis for my opinion is that I have personally treated several cases of Delusional Disorder and have carried out a systematic review of the literature, including a computerized search of published literature through the National Library of Medicine from 1966 to present, and a review of psychiatric textbooks. *See*, for example, Chapter 12 of the TEXTBOOK OF PSYCHIATRY, *Schizophrenia,*

Schizophreniform Disorder, and Delusional (Paranoid) Disorders (Talbott, et al. eds.) attached as *Exhibit B*.

6. The only systematic data that I could locate about the treatment of a large series of cases of Delusional Disorder have been reported by Opjordsmoen and Retterstol (PSYCHOPATHOLOGY, Volume 26, pages 90-94, 1993), a copy of which is attached as *Exhibit C*.

7. Opjordsmoen and Retterstol reported "The effect of neuroleptics in the treatment of schizophrenia is well established. Some reports indicate that at least pimozide may be effective in delusional disorder as well. In this article a long-term follow up study of 72 first-admitted patients with delusional disorder is described. Outcome in the group admitted during 1946-1948 was compared with that of patients admitted during 1958-1961. We did *not* find a more favorable outcome in the group admitted after the introduction of neuroleptics."

8. In other words, there is no evidence that neuroleptics are beneficial for patients with Delusional Disorder.

9. Although neuroleptics are often recommended by physicians for control of agitation or psychotic symptoms, there are no data to justify this as a benefit to patients with Delusional Disorder.

10. This finding is consistent with my own experience; whereas neuroleptics are often beneficial in schizophrenia, they are not beneficial in Delusional Disorder.

11. Dr. Sell himself has been treated with antipsychotic medication in the past by Mr. McKinney at Barnes Hospital.

12. Dr. Sell's delusions did *not* respond as evidenced by his immediately discontinuing treatment with the medication and never returning to see Dr. McKinney.

13. Dr. Sell regarded that treatment as a terrible experience then and now.

14. This would not constitute an adequate trial of the medication in a patient with schizophrenia, but neither does it provide any basis to think he would be an exception to the rule that neuroleptics are not beneficial in Delusional Disorder.

15. More generally, neuroleptics may be indicated for acute control of agitation or dangerousness, but they always are associated with risk of side affects.

16. Their proposed use in Dr. Sell must be considered from the point of view of benefit versus risk and with regard to his consent.

17. In my opinion, I do not see any justification for involuntary treatments that carry any risk at all in the absence of documented evidence of benefit to the person.

18. Accordingly, in my opinion, the treatment of Dr. Sell should be limited to basic support and voluntary symptomatic treatment.

19. This would indicate a safe supportive milieu with access to exercise and reading material.

20. The voluntary symptomatic treatment should include access to continued pharmacotherapy with antidepressants, which he has found helpful to his mood and energy level in the past.

FURTHER AFFIANT SAITH NOT.

/s/ C. Robert Cloninger
C. Robert Cloninger, M.D.

STATE OF MISSOURI)
) ss.
COUNTY OF ST. LOUIS)

On this 5 day of May, 1999, before me personally appeared C. Robert Cloninger, M.D., to me known to be the person described in and who executed the foregoing instrument, and acknowledged that he executed the same as his free act and deed.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal in the City and State aforesaid, the day and year first above written.

/s/ Geraldine L. Ford
Notary Public

My commission expires:

Aug. 16, 2002

GERALDINE L. FORD
NOTARY PUBLIC STATE OF MISSOURI
ST. LOUIS CITY
MY COMMISSION EXPIRES [Illegible] 2002

EXHIBIT A

CURRICULUM VITAE

C. Robert Cloninger, M.D.
465-76-6841

Date: September, 1998

Birthplace: Beaumont, Texas

Citizenship: U.S.A.

Address: Office: Department of Psychiatry
Washington University Medical School
4940 Children's Place
St. Louis, MO 63110
314-362-7005 (phone)
314-362-5594 (fax)

Home: 7100 Delmar
University City, MO 63130
314-863-1338

Present Position: Wallace Renard Professor of Psychiatry, also Professor of Genetics & Psychology, and Director of Center for Psychobiology of Personality

Education:

University of Texas, Austin, Texas, 1962-1966, B.A. with high honors and special honors in Plan II (Philosophy, Psychology, and Anthropology).

Washington University School of Medicine, St. Louis, MO 1966-1970, M.D.

Epidemiology Field Research Trainee, California State Department of Public Health, Berkeley, California, July 1967-September 1967.

Student Research Fellow (with S.B. Guze), Washington University School of Medicine, St. Louis, Missouri, June 1969-October 1969.

Assistant Resident-Assistant and Trainee (NIMH) in Psychiatry Washington University School of Medicine, St. Louis, Missouri, July 1970-June 1973.

Research Scientist Development Awardee (NIMH) in Quantitative Genetics, July 1975-1985.

Visiting Investigator, Population Genetics Laboratory, University of Hawaii at Manoa, July 1978-June 1979.

Academic Positions/Employment:

Instructor in Psychiatry, Washington University School of Medicine, St. Louis, Missouri, July 1973-June 1974

Assistant Professor of Psychiatry, Washington University School of Medicine, St. Louis, Missouri, July 1974-June 1978.

Associate Professor of Psychiatry, Washington University School of Medicine, St. Louis, Missouri, July 1978-June 1981.

Associate Professor of Genetics, Washington University School of Medicine, St. Louis, Missouri, July 1979-June 1981

Visiting Professor of Psychiatry and Genetics, University of Umea School of Medicine, Umea, Sweden, May to June, 1980.

Professor of Psychiatry and Genetics, Washington University School of Medicine, July 1981-present.

Head, Department of Psychiatry, Washington University School of Medicine, July 1989-March 1994

Professor of Psychology, Washington University, July 1989-present.

Wallace Renard Professor of Psychiatry, Washington University, July 1991-present

Director, Center for Psychobiology of Personality, March 1994-present

Hospital Appointments:

Barnes and Allied Hospitals, St. Louis, MO
Assistant Psychiatrist, July 1973-June 1980
Associate Psychiatrist, July 1980-June 1981
Psychiatrist, July 1981-present
Psychiatrist-in-chief July 1989-March 1994

Children's Hospital of St. Louis
Psychiatrist-in-chief, July 1989-June 1991

Malcolm Bliss Mental Health Center, St. Louis, MO
Consulting Psychiatrist, July 1973-1989

Jewish Hospital of St. Louis, MO
Associate Psychiatrist, July 1976-June 1980
Psychiatrist, July 1980-Present
Director of Outpatient Psychiatry, July 1976-June 1989

Other University Appointments and Committees:

Steering Committee Member, McDonnell Center for Higher Brain Function, 1989-1993

Steering Committee Member, WUMS Howard Hughes Program, 1990-1993

Chair, Division of Biostatistics Advisory Committee, 1989-1993

Member, Health Care Administration Advisory Committee, 1989-1993

Member, Occupational Therapy Program Advisory Committee, 1990-1993

Medical Licensure and Board Certifications:

State Board of the Healing Arts of Missouri, Physicians and Surgeons #32703, issued June 20, 1970

Missouri Controlled Substance Registration #210508

Bureau of Narcotic and Dangerous Drugs #AC4359419

Diplomate, American Board of Psychiatry and Neurology, 1975

Honors and Awards:

Institute of Medicine, National Academy of Sciences, USA, elected active member, May 1989-present

Fellow, American Association for the Advancement of Science, 1996-present, for outstanding contributions in the field of psychiatry, especially alcoholism and personality disorders

Phi Beta Kappa – 1965

Phi Beta Sigma – 1963

Alpha Epsilon Delta – 1965

Sandoz Award for Research in Psychiatry, Washington University School of Medicine (1970)

Research Scientist Development Awards:
Type 1 (1975-1980) MH-0048. The transmission and prognosis of psychiatric disorders (Quantitative Genetics and Environmental Genetic Interaction)

Type 2 (1980-1985) Genetic epidemiology of psychiatric disorders

Research Scientist Award (MH-00048)
Genetic Epidemiology of Psychiatric Disorders (1985-1989) (Resigned to accept chairmanship)

Endowed Visiting Professorships
Milton and Harriet Parker Memorial Lecturer, Ohio State University, Department of Psychiatry, September 1983 and December 1985

John Nielson Distinguished Lecturer, University of Utah, Department of Psychiatry, April 1988

Stewart Wolf Distinguished Lecturer, University of Oklahoma, Department of Medicine, May 1988

James Brady Lecturer, University of Colorado, 1989

Frank H. Luton Lecturer, Vanderbilt University, 1989

William D. Stubenbord Visiting Professor,

Cornell University Medical College and the Louis Calder Foundation, September, 1991

Other Distinguished Lectureships
Sigma Xi Lecturer on Natural Sciences, University of North Carolina, October 1987

NIH Centennial Lecturer, Washington, DC, September 1987

Plenary Lecturer, Research Society on Alcoholism, June 1988

Pfizer Visiting Professor, Columbia University and New York State Psychiatric Institute, October 1991

Gudbrandsdalen Medalist & Lecturer, Norwegian Medical Research Council, Lillehammer, Norway, 1992

Keynote Speaker, Australian-New Zealand Psychiatric Association Annual Meeting, Christchurch, New Zealand, 1993 and 1996

Lederle Visiting Professor, Hospital de la Salpetriere, Paris, France, December, 1993

Plenary Lecturer, Japanese Society of Psychosomatic Medicine, Kyoto, Japan, 1996

Plenary Lecturer, American College of Psychiatry, Kauai, Hawaii, 1996

Charles E. Smith Lecturer, National Institute for Psychobiology in Israel, Hebrew University, Jerusalem, Israel (Psychobiology of Human Personality), March 5, 1998

Honorary Doctor of Medicine (M.D. honoris causa), University of Umea (Sweden), October 1983 for distinguished contributions to genetic epidemiology of psychiatric disorders

Strecker Award (The 25th Annual Institute of Pennsylvania Hospital Award in Memory of Edward A. Strecker, M.D.), 1988 for significant contributions to psychiatric patient care and treatment by studies of the assessment and inheritance of personality and psychopathology

Edgehill Newport Scientific Recognition Award, May 1990, in recognition of outstanding contributions to the treatment of chemically dependent persons through basic research

Mortimer Goodman Memorial Award, The Alliance for the Mentally Ill of Metro St. Louis, in recognition

of outstanding service as a physician, researcher, administrator, public servant and friend, May 1992

James B. Isaacson Memorial Award, June 1992, International Society for Biomedical Research on Alcoholism and National Foundation for Prevention of Chemical Dependency Disease, for excellence in scientific research into the causes of chemical dependency diseases

Samuel Hamilton Award, March 1993, American Psychopathological Association, for contributions to understanding personality and psychopathology

Adolf Meyer Award, May 1993, American Psychiatric Association, for outstanding contributions to the science and practice of psychiatry

Editorial Responsibilities:

Editor, *Behavior Genetics* (1980-1986)
Associate Editor,
American Journal of Human Genetics (1980-1983)
Journal of Clinical Psychiatry (1981-1987)
Genetic Epidemiology (1983-1991)
Human Heredity (1989-Present)
Field Editor, *Neuropsychiatric Genetics. American Journal Medical Genetics* (1992-)
Editorial Boards,
Archives of General Psychiatry (1987-)
Neuropsychopharmacology (1991-)
Comprehensive Psychiatry (1992-)
Journal of Psychiatric Research (1993-)
American Journal of Medical Genetics (1993-)
Psychiatric Genetics (1993-)
International Journal of Neuropsychopharmcology (1997-)

Professional Societies and Organizations:

Advances in Neuropyschiatry and Psychopharmacology Editorial Board – Raven Press (1991-1993)

American Association for the Advancement of Science, Member (1976-Present)

Representative of the Behavior Genetics Association Section Committee for Medical Sciences (Section N) (1986-1989)

American College of Neuropsychopharmacology, Member (1987-)

Committee on Issues of Public Concern (1988-1997)

American Medical Association, Member (1982-Present)

American Psychiatric Association, Member (1975-1979)
Fellow (1980-Present)

American Psychopathological Association, Fellow (1976-Present)
Membership Chairman (1978-1984)
Treasurer (1984-1990)
Vice-President (1990-1991)
President-Elect (1991-1992)
President (1992-1993)

American Society of Human Genetics, Member (1976-Present)

Behavior Genetics Association, Member (1976-Present)
BGA Representative to AAAS Section Committee for Medical Sciences
Chairman, Publications Committee (1986-1989)

Center for Advanced Study in the Behavioral Sciences, Academic Psychiatry Consortium (1990-1993, 1993-1996)

Eastern Missouri Psychiatric Society, Member (1973-Present)

International Society for Study of Personality Disorders,
Board of Directors – (1991-)
President, American Region – (1993-)

Psychiatric Research Society, Member (1977-Present)

Research Society on Alcoholism (1981-Present)
Committee on Research Development (1984-Present)
Member, Board of Directors (1987-1990)
Committee on Issues of Public Concern (1989-91)

Society of Biological Psychiatry, Member (1977-Present)

Consulting Relationships and Board Memberships:

Consultant, American Psychiatric Association
Task Force on Nomenclature (Diagnostic and Statistical Manual – 111), 1978-1980
Task Force to Evaluate DSM-III, 1983-
Committee to Revise DSM-III, 1984-1987
Task Force on DSM-IV, 1988-

Psychiatric Consultant and Member of Professional Advisory Council, Suicide Prevention Service of Madison – St. Clair Counties (1971-1993)

Psychiatric Consultant, 3rd Judicial Circuit of Illinois (1973-1974)

Special Consultant and Site Visitor, NIMH Clinical Program Projects and Clinical Projects Review Committees (1977-1980)

NIMH Psychopathology and Clinical Biology Research Review Committee:
Consultant and Committee Member (1980-Present)

Chairman, Psychopathology Subcommittee (June 1981-1983)
Chairman (June 1983-July 1984)

Scientific Advisory and Consultant, NIMH Affective and Anxiety Disorders Research Branch (1986-1989)

Scientific Advisory Board
Children of Alcoholics Foundation (1989-present)

Consultant to Director, NIAAA (1984-1997)
Board of Scientific Counselors (1988-1992)

Consultant, World Health Organization (WHO)/ADAMHA Advisory Group on Diagnosis and Classification of Mental Disorders, and Alcohol – and Drug-Related Problems (1981-1985)
Consultant Psychiatrist (1993-present)

Member, Research Advisory Council, Texas Department of Mental Health and Mental Retardation (1983-1985)

Extramural Scientific Advisor and Consultant
Chicago Medical School, Department of Psychiatry (1977)
New York University Medical School, Psychiatry (1980-82)
University of Minnesota, Dight Laboratories, Genetics (1985-88)
University of Connecticut, Alcoholism Research Center (1986-91)
University of Pennsylvania, Clinical Research Center (1987-present)
University of Colorado, Alcohol Research Center (1991-)
University of Oklahoma, Alcoholism Research Center (1987-92)

Honorary Member – IBC Advisory Council, 1989

Scientific Advisory Board – Oklahoma Center of Molecular Medicine, 1990

Missouri Mental Health Commission – (9/26/90-6/28/94)

Pfizer Visting Professorship in Psychiatry Academic Advisory Committee, 1993-1996

Science Advisory Board, Treatment and Research Advancements – Association for Personality Disorder – (1997-)

Science Advisory Board, Treatment and Research Advancements – Association for Personality Disorder – (1997-)

Research Support:

Governmental:

NIMH, MH31302, Epidemiological Genetics and Family Study, C.R. Cloninger, M.D., P.I.; 08/01/86-07/31/2001

NIAAA, AA07982, Prediction of Alcohol Abuse in Swedish Adoptees, C.R. Cloninger, M.D. P.I.; 07/01/88-06/30/95

NIAAA, AA08028, Molecular Genetic Studies of Alcoholic Subtypes, C.R. Cloninger, M.D., P.I.; 12/01/88-11/30/95

NIMH, MH46276, Diagnostic Center for Linkage Studies of Schizophrenia, C.R. Cloninger, M.D., P.I.; 09/30/89-08/31/94

NIAAA, AA08401, Collaborative Studies on the Genetics of Alcoholism, Coordinating Center, Theodore Reich, M.D., P.I.; 10/01/89-09/30/94

NIMH, MH46280, Diagnostic Center for Linkage Studies of Bipolar Disorder, Theodore Reich, M.D., P.I.; 09/30/89-08/31/94,

MH14677, Research Training in Clinical Sciences, C.R. Cloninger, M.D., P.I.; 07/01/92-06/30/97 (transferred to T. Reich, 7/1/93)

Teaching Titles and Responsibilities:

Coursemaster, Introduction to Clinical Psychiatry – Washington University School of Medicine II (1976-1989)

Committee on Academic Review and Promotion (1976-1989)

Lecturer, Medical Genetics, Washington University School of Medicine (1980-Present)

Clinical Sciences Postdoctoral Training Program
Preceptor (1975-Present)
Psychiatric Genetics Director (1980-Present)
Overall Program Director (1985-1993)

RESEARCH TRAINEES

Betty Lobos, B.S., Predoctoral Graduate Student (1985-1993)
Training: Quantitative and molecular genetics.
Dissertation Topic: Genetics of Nicotine Acetylcholine Receptor.

Sean Yutzy, M.D., Postdoctoral Fellow, (1990-1992)
Training: Nosology of somatoform and personality disorders
Currently: Assistant Professor of Psychiatry, Washington University School of Medicine

Dragan M. Svrakic, M.D., Ph.D., Fulbright Scholar from University of Belgrade, Yugoslavia (Sept 88-Aug 89)

Training: Collaboration on Cross-cultural studies of personality assessment and structure.
Currently, Assistant Professor of Psychiatry, Washington University School of Medicine

Stephen Dinwiddie, M.D., Postdoctoral Fellow (1987-1990)
Training: Clinical and genetic methods for studying neuroadaptive processes in substance abusers.
Currently: Assistant Professor of Psychiatry, Washington University School of Medicine

Ronald Martin, M.D., Psychiatry Resident, 1975-1977
Training: Supervised his follow-up of female felons I had previously studied; trained in conduct and analysis of longitudinal clinical studies
Currently: Professor & Chairman of Psychiatry, University of Kansas at Wichita.

Collins E. Lewis, M.D., M.P.H., Psychiatry Resident, 1975-1977
Training: Supervised clinical and family study of alcoholics; trained in epidemiological methods and family studies.
Currently: Associate Professor of Psychiatry, Washington University.

William Coryell, M.D., Psychiatry Resident, 1977
Training: Supervised his participation in a reliability study of a new structured interview; trained in methods for conducting and interpreting reliability studies.
Currently: Professor of Psychiatry, University of Iowa.

John P. Rice, Ph.D., Postdoctoral Fellow, 1975-1977
Training: Directed reading about psychiatric genetics and genetic epidemiology; we jointly

worked on extending methods for cultural inheritance and segregation analysis.
Currently: Professor of Psychiatry & Biostatistics, Washington University.

Andrew Scallet, Ph.D., Predoctoral Psychology Student, 1975-1976
Training: Supervised research on assessment and doubleblind treatment studies of outpatients.
Currently: Research Psychologist, National Center for Toxicological Research, Jefferson, Arkansas

Lenore Teter, M.D., Psychiatry Resident, 1980
Training: Supervised research on psychiatric social adjustment of recent Russian immigrants.
Currently: Instructor in Psychiatry, Washington University, then private practice

Robert Desalle, B.S., Predoctoral Genetics Fellow, 1979
Training: Method of path analysis in studying inheritance of complex phenotype systems.
Currently: Completed dissertation in Genetics, Washington University.
Currently: Department of Biology, Yale University

Peter McGuffin, M.D., Postdoctoral Fellow, 1980-1981
Training: Advanced methods of genetic epidemiology including segregation, path, admixture, and linkage analysis.
Currently: Professor & Chairman of Psychiatry, Cardiff, England

Paul Van Eerdewegh, Ph.D., Predoctoral Fellow, 1980-1982
Training: Studies of statistical properties of copaths and selection in multivariate systems relevant in quantitative genetics.

Currently: Assistant Professor in Psychiatry in Genetic Epidemiology, Washington University.

Dennis O'Rourke, Ph.D., Postdoctoral Fellow, 1980-1983
Training: Advanced methods of genetic epidemiology including segregation, path, and linkage analysis.
Currently: Professor of Anthropology, University of Utah.

Anne-Liss von Knorring, M.D., Postdoctoral Fellow, 1982-1983.
Training: Methods of genetic epidemiology relevant to adoption studies.
Currently: Professor of Child Psychiatry, University of Uppsala, Sweden.

Soren Sigvardsson, D. Med. Sci., Predoctoral Fellow, 1981 Postdoctoral Fellow, 1983
Training: Methods of genetic epidemiology and multivariate analysis relevant to adoption studies; longitudinal and cross-fostering studies of adoptees with relevance to child psychiatry.
Currently: Associate Professor of Child Psychiatry, Umea University.

Nancy J. Cox, Ph.D., Postdoctoral Fellow, 1982
Training: Advanced methods of genetic epidemiology for studying psychiatric disorders.
Currently: Assistant Professor, University of Chicago.

Eric Devor, Ph.D., Postdoctoral Fellow, 1982
Training: Advanced methods of genetic epidemiology in anthropology; population structure.
Currently: Assistant Professor of Psychiatry, University of Iowa, Iowa City

Mark Zoccolillo, M.D., Psychiatry Resident, 1983
Training: Supervised design and analysis of clinical and social comparison of matched groups of outpatients with somatoform and affective disorders; study of parenting and home environmental influences on children of outpatients.
Currently: Assistant Professor of Psychiatry, Texas Tech

Edward Lauterbach, M.D., Psychiatry Resident, 1984
Training: Design and analysis of psychiatric follow-up studies.
Currently: Associate Professor of Psychiatry, (Tenure) Mercer University School of Medicine, Macon, Georgia

Kara Forest, B.A., Biology Honors Student, 1986
Training: Etiology of anxiety states.
Currently: Medical school

Wolfgang Baier, M.D., FRG Postdoctoral Fellow, 1987
Training: Genetic epidemiology of generalized minor seizures (collaborative project with Professor Doose at University of Kiel, FRG)
Currently: Child Neurologist, University of Kiel

David Craufurd, M.D., Wellcome Trust Fellow, 1987.
Training: Psychiatric Genetics.
Currently: Research Psychiatrist, St. Mary's Hospital, University of Manchester, England.

Sheila B. Gilligan, B.S., Predoctoral Graduate Student (1983-1988)
Training: Quantitative genetics of common diseases. Dissertation Topic: Genetic and Phenotypic Heterogeneity in Alcoholism (scheduled to complete Spring, 1988).
Currently: Postdoctoral Fellow in Human Genetics, Medical College of Virginia (Dr. Andrew Heath), then Peace Corps in Africa.

Vicky Ryan, Undergraduate biology honors student (1987-1988)
Training: Techniques in family studies of alcoholism.
Currently: Medical School, University of Missouri

David L. Garver, M.D., Sabbatical Leave from University of Cincinnati, Depts. of Psychiatry and Pharmacology (Sept 88-Aug 89)
Training: Psychiatric genetics including clinical and molecular aspects.
Currently: Professor of Psychiatry, Southwestern Medical School, Dallas, Texas

Harald and Gabrielle Aschauer, M.D., Medical Research Council of Austria Fellows
Training: Neuropsychopharmacologist/psychiatrist coming for training in genetics of schizophrenia (Sept 87-March 1989).
Currently: Assistant Professors in Vienna

Bibliography

Articles – 1970

1. Cloninger CR and Guze SB: Psychiatric Illness and Female Criminality: The Role of Sociopathy and Hysteria in the Antisocial Women. *Amer. J. Psychiat.*, 127(3):303-311, 1970.

2. Cloninger CR and Guze SB: Female Criminals: Their Personal, Familial, and Social Backgrounds (The Relations of These to the Diagnoses of Sociopathy and Hysteria). *Arch. Gen. Psychiat.*, 23:554-558, 1970.

Articles – 1973

3. Cloninger CR and Guze SB: Psychiatric Illness in the Families of Female Criminals: A Study of 288

First-Degree Relatives. *Brit. J. Psychiat.*, 122:697-703, 1973.

4. Cloninger CR and Guze SB: Psychiatric Disorders and Criminal Recidivism: A Follow-up Study of Female Criminals. *Arch. Gen. Psychiat.*, 29:266-269, 1973.

Articles – 1974

5. Hearst ED, Cloninger CR, Crews EL, and Cadoret RJ: Electrosleep Therapy: A Double Blind Trial. *Arch. Gen. Psychiat.*, 30:463-466, 1974.

6. Cloninger CR: Group Rape: A Commentary. Med. Aspects of Human Sexuality, 8:81, 1974.

7. Cloninger CR, Packman PM, Cicero TJ, Boshans RL, and Robins E: Morphine Dependence and Enzyme Activity in the Hypothamus. *Biochem. Pharmacol.* 23:983-988, 1974.

Articles – 1975

8. Cloninger CR and Guze SB: Hysteria and Parental Psychiatric Illness. Presented at the Annual Meeting of APA, 1973. Psychol. Med., 5:27-31, 1975.

9. Reich T, Cloninger CR, and Guze SB: The Multifactorial Model of Disease Transmission: I. Description of the Model and its Use in Psychiatry. *Brit. J. Psychiatry*, 127:1-10, 1975. (Science citation Index Citation Classic)

10. Cloninger CR, Reich T, and Guze SB: The Multifactorial Model of Disease Transmission: II. Sex Differences in the Familial Transmission of Sociopathy (Antisocial Personality). *Brit. J. Psychiatry*, 127:11-22, 1975.

11. Cloninger CR, Reich T, and Guze SB: The Multifactorial Model of Disease Transmission: III. Familial Relationship Between Sociopathy and Hysteria (Briquet's Syndrome). *Brit. J. Psychiatry*, 127:23-32, 1975.

12. Cloninger CR: Recognizing and Treating Sociopathy. *Medical World News*, 16(23):12-18, 1975.

13. Cloninger CR, Reich T and Guze SB: Genetic-Environmental Interactions and Antisocial Behavior. In Psychopathic Behavior: Approaches to Research, (Eds. RD Hare and D Schallings). Proceedings of the NATO Advanced Study Institute on Psychopathic Behavior, Les Arcs, France. September 5-12, 1975. Chichester: John Wiley and Sons, 1978, pages 225-238.

14. Cloninger CR: The Link Between Hysteria and Sociopathy. Chapter 11 in *Psychiatric Diagnosis: Exploration of Biological Predictors*. Predictors in Psychiatric Diagnosis, Memphis, Tennessee, December 7-9, 1975. (Eds. HS Akiskal and WL Webb). New York: Spectrum, Inc. 1978, pages 189-218.

Articles – 1976

15. Scallet A, Cloninger CR, and Othmer E: The Management of Chronic Hysteria: A Review and Double Blind Trial of Electrosleep and Other Relaxation Methods. *Dis. Nerv. System*, 37(6):347-353, 1976.

16. Woodruff RA, Clayton P, Cloninger CR, and Guze, SB: A Brief Method of Screening for Alcoholism. *Dis. Nerv. System*, 37(8):434-435, 1976.

Articles – 1977

17. Hill S, Cloninger CR, and Ayre F: Independent Familial Transmission of Alcoholism and Opiate Abuse. *Alcoholism: Clinical and Experimental Research*, 1(4):335-342, 1977.

18. Guze SB, Akiskal HS, Cadoret R, Cloninger CR, Matthysse S, and Rosenthal D: Family and Genetic History as Diagnostic Predictors. Chapter 12 in *Psychiatric Diagnosis: Exploration of Biological Predictors*, op. cit., pages 219-233.

19. Liskow BI, Clayton P, Woodruff R, Guze SB, and Cloninger CR: Briquet's Syndrome, Hysterical Personality, and the MMPI. *Amer. J. Psychiat.*, 134(10):1137-1139, 1977.

Articles – 1978

20. Cloninger CR, Christiansen KO, Reich T, and Gottesman II: Implications of Sex Differences in the Prevalence of Antisocial Personality, Alcholism, and Criminality for Models of Familial Transmission. *Arch. Gen. Psychiat.*, 35:941-951, 1978.

21. Martin RL, Cloninger CR, and Guze SB: Female Criminality and the Prediction of Recidivism: A Prospective Six Year Followup. *Arch. Gen. Psychiat.*, 35:207-214, 1978.

22. Coryell W, Cloninger CR, and Reich T: Clinical Assessment: Use of Non-Physician Interviewers. *J. Nerv. Ment. Dis.*, 166(8):599-606, 1978.

23. Powell C, Miller JP, and Cloninger CR: The Use of SAS for the Analysis of Family Studies. In Strand, RH (Ed.), *Proceedings of the Third Annual Conference on the SAS User's Groun International*. SAS Institute, Inc., Raleigh, North Carolina, 1978, pp. 189-194.

24. Reich T, Cloninger CR, Lewis CE, and Rice J: Familial Structures in Models of Cultural Inheritance. In NE Morton and CS Chung (Eds.) *Genetic Enidemiology*. Academic Press, 1978, pp. 183-191.

25. Cloninger CR, Matthysse S, Anderson VE, and Morton NE: Panel Discussion: Resolution of Etiologic Heterogeneity in the Psychoses. In NE Morton and CS Chung (Eds.), *Genetic Epidemiology*. Academic Press, 1978, pp. 329-330.

26. Rice J, Cloninger CR, and Reich T: Multifactorial Inheritance with Cultural Transmission and Assortative Mating. I. Description and Basic Properties of the Unitary Models. *Am. J. Hum. Genet.*, 30:618-643, 1978.

27. Cloninger CR: Antisocial Personality. Hospital Practice, 13(8):97-112, 1978. Reprinted in Guggenheim F, Nadelson CC (Eds.), *Handbook of Major Psychiatric Disorders: Overviews and Selected Readings*. Elsevier North Holland, pp. 169-178, 1982.

Articles – 1979

28. Cloninger CR, Miller JP, Wette R, Martin RL, Guze SB: The Evaluation of Diagnostic Concordance in Follow-up Studies: I. A General Model of Causal Analysis and a Methodological Critique. *J. Psychiat. Research*, 15:85-106, 1979.

29. Martin RL, Cloninger CR, Guze SB: The Evaluation of Diagnostic Concordance in Follow-up Studies: II. A Blind Prospective Follow-up of Female Criminals. *J. Psychiat. Research*, 15:107-125, 1979.

30. Cloninger CR, Reich T, Wetzel R: Alcoholism and the Affective Disorders: Familial Association and Genetic Models. In: *Alcoholism and the Affective Disorders* (eds. D Goodwin and C Erickson). New York: Spectrum Press, pages 57-82, 1979.

31. Reich T, Rice J, Cloninger CR, Wette R, James J: The Use of Multiple Thresholds and Segregation Analysis in Analyzing the Phenotypic Heterogeneity

of Multifactorial Traits. *Annals of Human Genetics*, London, 42(3): 371-390, 1979.

32. Cloninger CR, Rice J, Reich T: Multifactorial Inheritance with Cultural Transmission and Assortative Mating. II. A General Model of Combined Polygenic and Cultural Inheritance. *Am. J. Hum. Genet.*, 31:176-198, 1979.

33. Cloninger CR, Rice J, Reich T: Multifactorial Inheritance with Cultural Transmission and Assortative Mating. III. Family Structure and the Analysis of Separation Experiments. *Am. J. Hum. Genet*, 31:366-388, 1979.

34. Rice J, Reich T, Cloninger CR, Wette R: An Approximation to the Probabilities of the Multivariate Normal Distribution: Its Application to the Multifactorial Model of Qualitative Traits. *Biometrics*, 35:451-459, 1979.

35. Rao DC, Morton NE, Cloninger CR: Path Analysis Under Generalized Assortative Mating. I. Theory. *Genetical Research*, Cambridge: 33:175-188, 1979.

Articles – 1980

36. Reich T, Rice J, Cloninger CR, Lewis C: The Contribution of Affected Parents to the Pool of Affected Individuals: Path Analysis of the Segregation Distribution for Alcoholism. In: *The Social Consequences of Psychiatric Illness*, LN Robins, P Clayton, J Wing, (Eds.) Brunner/Mazel, pp. 91-113, 1980.

37. Rice J, Cloninger CR, Reich T: The Analysis of Behavioral Traits in the Presence of Cultural Transmission and Assortative Mating. Application to IQ and SES. *Behavior Genetics*, 10:73-92, 1980.

38. Wetzel RD, Cloninger CR, Hong B, Reich T: Personality as a Subclinical Expression of Affective Disorder. *Comprehensive Psychiatry*. 21:197-205, 1980.

39. Reich T, Cloninger CR, Lewis C, Rice J: Some Recent Findings in the Study of Genotype-environment Interactions in Alcoholism. Proceedings of the University of Connecticut – NIAAA Conference on "Evaluation of the Alcoholic: Implications for Research, Theory, and Treatment", *NIAAA Research Monograph Series*, pp. 145-165, 1980.

40. Reich T, Suarez B, Rice J, Cloninger CR: Current Directions in Genetic Epidemiology. In: *Current Developments in Anthropological Genetics*, Vol. I (J Mielke and M Crawford, eds.), Plenum Press, New York, pp 299-324, 1980.

41. Cloninger CR, Lewis C, Rice J, Reich T: Strategies for the Resolution of Biological and Cultural Inheritance. In: *Genetic research Strategies for Psychobiology and Psychiatry*. (ES Gershon, S Matthysse, XO Breakefield, RD Ciaranello, editors). Boxwood Press, Pacific Grove, California, pages 319-332, 1980.

42. Reich T, Rice J, Cloninger CR: The Detection of a Major Locus in the Presence of Multifactorial Variation. In: *Genetic Research Strategies for Psychobiology and Psychiatry*, op. cit, pp. 353-368, 1980.

43. Rice J, Cloninger CR, Reich T: General Causal Models for Sex Differences in the Familial Transmission of Multifactorial Traits: An Application to Human Spatial Visualizing Ability. *Social Biology*, 27:36-47, 1980.

44. Cloninger CR: Interpretation of Intrinsic and Extrinsic Structural Relations by Path Analysis:

Theory and Applications to Assortative Mating. *Genetical Research*, Cambridge, 36:122145, 1980.

Articles – 1981

45. Cloninger R, Martin RL, Guze SB, Clayton P: A Blind Follow-up and Family Study of Anxiety Neurosis: Preliminary Analysis of the St. Louis 500. In: *Anxiety:, New Research and Changing Concepts*, edited by DF Klein and J Rabkin. New York: Raven Press, pages 137-150, 1981.

46. Rice J, Miller JP, Cloninger CR: Path Analytic Models in Human Quantitative Genetics. In *Proceedings of the Sixth Annual Conference of the SAS User's Group International*. Institute, Inc., Raleigh, North Carolina, pp. 110-115, 1981.

47. Rice J, Reich T, Cloninger CR: Models for the Familial Transmission of Alcoholism: Path Analysis and Multifactorial Segregation Analysis. *Psychopharmacclogy Bulletin*, 17:40-42, 1981.

48. Cloninger CR, Bohman M, Sigvardsson S: Inheritance of Alcohol Abuse: Cross-fostering Analysis of Adopted Men. *Arch. Gen. Psychiatry*, 38:861-868, 1981.
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49. Bohman M, Sigvardsson S, Cloninger CR: Maternal Inheritance of Alcohol Abuse: Cross-fostering Analysis of Adopted Women. *Arch. Gen. Psychiatry*, 38:965-969, 1981.

50. Smith EM, Cloninger CR: Alcoholic Females: Mortality and Twelve-Year Follow-up. *Focus on Women: Journal of Addictcn and Health*, 2:1-13, 1981.

Articles – 1982

51. Reich T, Cloninger CR, Suarez B, Rice J: Genetics of the Affective Psychoses. In: *Handbook of Psychiatry*, Vol. 3 (JK Wing, L Wing, editors). Cambridge, University Press, pp. 1437-159, 1982.

52. Wetzel RD, Cloninger CR, Guze SB The Assessment of Patients with Neurosis: In Burdock, EJ, Sudilovosky A, Gershon S (eds). *Quantitative Techniques for the Evaluation of the Behavior of Psychiatric Patients*, New York, Dekker, Chapter 18, pp. 439-484, 1982.

53. Cloninger CR, Rice J, Reich T, and McGuffin P: Genetic Analysis of Seizure Disorders as Multidimensional Threshold Characters. *In Genetic Basis of the Epilepsies*, edited by VE Anderson, WA Hauser, JK Penry, CF Cing, Raven Press, pp. 291310, 1982.

54. Martin RL, Cloninger CR, and Guze SB: Alcoholism and Female Criminality. *J Clinical Psychiatry*, 43:400-403, 1982.

55. Cloninger CR, Sigvardsson S, Bohman M: Discriminant Analysis of Adoption Studies: A reply to Cadoret and Brier. *Arch Gen Psychiatry*, 39:974-975, 1982.

56. Cloninger CR: Contributions of Biogenetic Research to Classification of Psychiatric Disorders. *Proceedings of WHO/ADAMHA Conference on International Diagnosis and Classification of Mental Disorders*. WHO Publication, Geneva, 1982.

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EXHIBIT B

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Chapter 12

Schizophrenia, Schizophreniform Disorder, and Delusional (Paranoid) Disorders

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* * *

□ DELUSIONAL (PARANOID) DISORDERS

Delusional (paranoid) disorders constitute a small but important group of disorders. The *DSM-III-R* includes persecutory, jealous, erotomanic, grandiose, and somatic subtypes, all unified by the presence of a dominant, well-systematized, and encapuslated nonbizarre delusion accompanied by affect appropriate to the delusion; personality deterioration is minimal.

History

The term *paranoia* has ancient roots. From the Greek *para nous*, meaning "a mind beside itself," the term was originally used in Greek literature to describe insanity or "craziness." The term fell into disuse but was revived in the early 19th century by German psychiatrists who were interested in disorders characterized by delusions of persecution and grandeur (Lewis 1970; Tanna 1974). Kahlbaum, in 1863, used the term to describe a chronic delusional condition. Kraepelin separated paranoia from dementia praecox and, like Kahlbaum, was concerned with longitudinal course. Kraepelin gradually altered his concept of paranoia, so that by the eighth revision of his *Lehrbach der Psychiatric*, he had restricted the term to describe those with systematized delusions, an absence of hallucinations, and a prolonged course without recovery but not generally leading to mental deterioration. He also identified *paraphrenia* as an intermediate group of paranoid disorders between dementia praecox and paranoia

characterized by unremitting systematized delusions and hallucinations without progression to dementia. The latter term is still used commonly in Britain. Bleuler agreed that paranoia was separate from dementia praecox but differed from Kraepelin in maintaining that hallucinations could occur in some cases. He was particularly interested in the psychological development of the disorder.

Modern Scandinavian practice is to regard delusional disorders as reactive, arising in persons with vulnerable constitutions subjected to stress. Their term, paranoid psychotic reaction, would include contemporary American concepts of paranoia, but also schizophreniform and schizoaffective disorders.

Contemporary American thought on the disorder is represented in *DSM-III* and is remarkably similar to the definition put forth by Kraepelin in 1912 and 1919. The ICD-9 defines paranoia similarly. Winokur (1977) suggested that paranoid disorder be renamed *delusional disorder* to rid the diagnosis of the ambiguity inherent in the term *paranoia*, which most persons construe to mean persecutory. Winokur and others have demonstrated that delusions found in paranoid disorders are not restricted to delusions of persecution or jealousy. These suggestions have now been incorporated into the revision of *DSM-III* (1987). Kendler (1980) has further proposed that in the absence of hallucinations, the term *simple delusional disorder* be used and that when hallucinations are present the term *hallucinatory delusional disorder* be used.

Epidemiology

Little is known about the true incidence and prevalence of delusional disorder. Much of our knowledge is based on

retrospective data of hospitalized patients and may not be generalizable. Kendler (1982) recently reviewed 17 reports on the frequency of paranoia for hospital admissions. He determined that delusional disorder constituted between one and four percent of psychiatric admissions and between two and seven percent of admissions for functional psychosis. He calculated the incidence of first admissions for paranoia to be between 1 and 3 per 100,000 per year and the prevalence to be between 24 and 30 per 100,000 population. From these reports, Kendler concludes that paranoia is an illness predominantly manifesting itself in middle to late adult life with a peak frequency of first admissions between 35 and 55 years of age. Patients are more likely to be female than male, with most reports showing that between 36 percent and 48 percent of first admissions are men. Sixty to 75 percent of patients first admitted are married, but up to one-third are widowed, divorced, or separated at the time of admission. Patients with the disorder are judged to be relatively socially disadvantaged, both in economic and educational terms, and are often immigrants. Kendler notes that these demographic characteristics are unlike those for schizophrenia or affective disorder and consistent with the hypothesis that delusional disorder is a distinct entity.

These data differ from those presented by Winokur (1977) in a chart review of 29 paranoics admitted to a state psychiatric hospital over a 50-year period. The 29 patients constituted 0.14 percent of all hospital admissions. Like Kraepelin, Winokur found that males predominated 70:30. He also found that 94 percent had an age of onset between ages 20 to 49, that over half had been ill more than four years at the time of admission, and that most patients had a satisfactory work history. In his study, more than half had IQs less than 90.

Etiology

Little is known about the genesis of delusional disorders. As one would expect, most theories involve genetics, the environment, or psychodynamics.

The weight of evidence suggests that delusional disorder is unrelated to either schizophrenia or affective disorders. In a recent review, Kendler (1980) found no increase in risk for affective illness in families of paranoid probands; two of three family studies reporting on the risk for schizophrenia showed a two-fold increased risk, while the other showed no increase. In a reanalysis of the Copenhagen sample of the Danish adoption study of schizophrenia, Kendler et al. (1982) found that cases of schizophrenia spectrum disorders (schizotypal personality and schizophrenia) were strongly concentrated in the biologic relatives of schizophrenic adoptees but not in adoptees with delusional disorder. A recent family study of 32 paranoics by Watt (1985) also found an increased risk for schizophrenia in first degree relatives of schizophrenics but not for paranoid or depressed probands.

Apparently, patients with delusional disorder differ from schizophrenics premorbidly as well. In three relevant studies (Kendler 1980), they are noted to be more extroverted, dominant, and hypersensitive, while schizophrenic patients premorbidly tend to be schizoid, introverted, or submissive. Unfortunately, there are no comparisons with affective disorders.

It is possible that psychosocial stressors have a role in the etiology of delusional disorder. Certain rare paranoid conditions illustrate this possibility. *Induced psychotic disorder* (shared paranoid disorder), or "folie a deux," occurs when delusions are transferred from one individual to another. Usually the dominant person in the relationship

develops a delusion; it is later passively adopted by the other. *Migration psychoses* are described in persons migrating to foreign countries. Certainly, persons in whom paranoia is prone to develop may be more likely to immigrate than others, but it is also possible that the particular psychosocial stress associated with immigration plays a causal role in the development of the psychosis. *Prison psychosis* has been described in which isolation in prison, especially solitary confinement, may lead to paranoia. *Querulent paranoia* is a special form of paranoia characterized by litigiousness and is believed by Scandinavian investigators to be a psychogenic disorder in which unlucky personal experiences precipitate paranoia in persons with deviant personalities. How, or why, these situations should lead to the development of paranoia is unclear.

The psychodynamic origin of paranoia stems from Freud's analysis of the Schreber case (Freud 1958a). Freud believed persecutory delusions to stem from unconscious homosexual urges defended against by denial and projection. However, there is apparently no increase in delusional disorder among homosexuals and vice versa.

Clinical Features and Differental Diagnosis

Delusional disorders, according to *DSM-III-R* (see Table 7), consistent of nonbizarre delusions lasting at least one month and involving situations that occur in real life, behavior that is not obviously odd or bizarre apart from the delusion or its ramifications, absence of schizophrenic symptoms such as bizarre delusions or grossly disorganized speech or behavior, no prominent hallucinations, and absence of an affective disorder or organic mental disorder. The core feature, however, is the presence of a

well-systematized nonbizarre delusion – a fixed false belief in the presence of an otherwise clear sensorium. Winokur (1977) found delusions of persecution, reference, and jealousy to be the most common while hypochondriacal delusions and delusions of grandeur are less common. Sexual problems and depressive symptoms are frequent and patients may show overtalkativeness or circumstantiality, especially when discussing their delusions. In his study, the patients were not considered fussy or obsessional by their families, but were considered to have been chronically jealous or suspicious. Interestingly, Winokur (1985) found these traits to be typical of family members as well.

TABLE 7. *DSM-III-R* CRITERIA FOR DELUSIONAL (PARANOID) DISORDER

A. Nonbizarre delusion(s) (that is, involving situations that occur in real life, such as being followed, poisoned, infected, or loved at a distance; having a disease; being deceived by one's spouse or lover) of at least one month's duration.

B. Auditory or visual hallucinations, if present, are not prominent.

C. Apart from the delusion(s) or its ramifications, behavior is not obviously odd or bizarre.

D. Major depressive or manic syndrome, if present, was brief in duration relative to the duration of the psychotic symptoms.

E. Has never met criterion A of schizophrenia (see Table I) and it cannot be established that an organic factor initiated and maintained the disturbance.

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Associated features may include anger, social isolation and seclusiveness, eccentric behavior, suspiciousness, hostility, and rarely violence. Many patients become litigious and end up as lawyers' clients rather than as psychiatrists' patients.

According to *DSM-III-R* delusional disorder includes the following subtypes: persecutory, jealous, erotomanic, grandiose, and somatic. *Unspecified type* is a residual category for patients who cannot be subtyped in the previous groups. Patients ill less than one month would be classified as either having a brief reactive psychosis or an atypical psychosis. In *DSM-III* this would have been classified as an acute paranoid disorder. The *DSM-III* category shared paranoid disorder, or "folie a deux," occurs when two or more persons share a delusion. This is a rare disorder and its incidence and prevalence are unknown. In *DSM-III-R* it is termed *induced psychotic disorder* and is grouped with psychotic disorders not elsewhere classified, rather than with delusional disorder.

Several variants of delusional disorder have been described and include (in addition to those identified earlier): *conjugal paranoia*, which is limited to the delusion about a spouse's perceived infidelity; *erotomani* (De Clerambault's syndrome), wherein a person, usually female, develops the belief that another person, usually an older male of social importance, is in love with her; hypochondriacal paranoia, wherein a patient has the unshakable belief of having a physical illness; Capgras syndrome, wherein a patient believes a person closely related to him or her has been replaced by a double; and Fregoli syndrome, in which the patient identifies a familiar person in various other people he or she encounters. The patient

may maintain that although there is no physical resemblance between the familiar person and others, they are nonetheless psychologically identical. It is important for a clinician to consider schizophrenia or an organic mental disorder as the cause of these variants. The following case report illustrates conjugal paranoia:

Case Example

H.M. is a 64-year-old electrician who lives with his wife of 43 years. Although his father was alcoholic, and his family poor, H.M. was well adjusted as a child, achieved good grades in school, and participated in sports activities, although he was considered somewhat aloof and distant by his peers. After graduating from high school he had married and joined the Army, serving honorably in World War II. After the war he worked as an electrician, eventually opening his own business. Although hard-working, he was viewed as overly rigid and humorless by his family and had few friends. H.M. and his wife had three children, all of whom were healthy and emotionally stable.

Several years after returning from the war, he began to suspect his wife of infidelity and over the ensuing decades continued to be convinced that his wife was constantly involved with other men. Although he had never seen her with another man, he was nevertheless convinced by trivial evidence such as frequently washed bed linen, spots on his wife's undergarments, or tire tracks in the driveway that did not belong there. He had accused his wife of placing sleeping pills in his coffee at night so that she would be able to leave the house for a liaison with her lover after he had fallen asleep. He maintained that on

several occasions his wife actually had sexual relations with another man in the same bed where he lay sleeping. On one particular occasion, he noted awakening to find the bed sheets in disarray and his shorts pulled down to his knees in what he believed was his wife's lover's attempt to harass him. He had also claimed that neighbors had commented to him about the large number of men who visited his wife when he was away.

His wife first became aware of his suspiciousness and jealousy early in their marriage and steadfastly maintained that there was no basis for the accusations. No amount of reassurance could alter her husband's convictions, however. She reported that during their marriage her husband's beliefs would wax and wane, alternating with periods of relative normalcy. Although she continued to love and care for him, his wife admitted that the delusional beliefs had strained the marriage and had led to several separations.

H.M. voluntarily presented for hospitalization reporting that he was tired of his wife calling him "crazy" and wishing to settle the matter. During the hospital stay he was friendly and appropriate, but persisted with the unshakable belief that his wife had been unfaithful to him. There was no evidence of hallucinations. A trial of antipsychotic medication did not alter his belief.

Diagnosis

Because delusional symptoms are common and frequently accompany both functional and organic illnesses, a careful diagnostic assessment is necessary. First, a thorough physical and history must rule out organic causes for delusional disorder. Delusional symptoms have been found

in a variety of organic illnesses including alcoholism; amphetamine-, cocaine-, and other-drug-induced states; dementia; and infectious, metabolic, and endocrine disorders (Manschreck and Petri 1978).

Routine lab tests may be helpful in ruling out organic causes. If mass lesions are suspected, CT or MRI may be useful in selected cases but are not routinely necessary.

The major differential remains in separating delusional disorder from affective disorder, schizophrenia, and paranoid personality. The chief distinction is that in delusional disorders, a full depressive or manic syndrome is absent, developed after the psychotic symptoms, or was brief induration relative to the duration of the psychotic symptoms,. Unlike schizophrenia, delusional disorder is characterized by nonbizarre delusions and generally either absence of hallucinations or hallucinations that are not prominent. Furthermore, patients with delusional disorder do not develop other schizophrenic symptoms, such as incoherence or grossly disorganized behavior, and personality is generally preserved in areas not involving the delusion. Persons with paranoid personality are suspicious and hypervigilant, but do not have delusions.

Treatment (Pharmacology and Psychotherapy)

There are no systematic data on treatment approaches and results in delusional disorder. Nonetheless, a combination of psychosocial and physical measures seems prudent. The initial obstacle is getting the patient to the physician. Because of distrust and suspiciousness this may be particularly difficult, and might account for the low percentage of cases reported by physicians. Hospitalization is indicated if a potential for danger is present;

otherwise outpatient management is advisable. In some cases, involuntary hospitalization will be mandatory, if the threat of self-harm or harm to others is present. Unfortunately, involuntary hospitalization may increase distrust and resentment and perhaps fuel a patient's persecutory delusions.

Tact and skill are necessary to persuade a patient to accept treatment. It may help to first convince the patient that he or she should have treatment for associated depressive symptoms or anxiety and not his or her delusions. Once a therapeutic relationship has been established, the physician may then gently challenge the patient's beliefs by showing how they interfere with the patient's life. The physician must neither condemn nor collude in the beliefs. Also, the patient should be assured of confidentiality and the physician should not discuss matters with the patient's family without the patient's awareness.

Insight-oriented psychotherapy and group therapy are generally not recommended because suspiciousness and hypersensitivity may lead to misinterpretation. Some clinicians, however, believe that dynamic approaches can be helpful (Meissner 1986). Needless to say, any psychosocial treatment recommendations are based on clinical observation, not empirical evidence.

Antipsychotic medication may be useful, particularly for accompanying anxiety, agitation, and psychosis. Although many investigators are pessimistic, others suggest that specific forms of delusional disorder, for example, monohypochondriacal paranoia, may have a good response to antipsychotic medication (Munro 1978). Any of the standard antipsychotics may be used, the type and

dose of which depending on age and side effects. Because patients may be suspicious of medication, depot forms may be helpful, once it is determined that the patient benefits from the medication.

Other treatments have been tried, including electroconvulsive therapy, insulin shock therapy, and psychosurgery, but results have not been encouraging, and these approaches are not recommended.

Course and Prognosis

Kahlbaum and Kraepelin both recognized the importance of longitudinal follow-up and both believed patients with delusional disorder to have a chronic, unremitting course. Winokur (1977) found that 79 percent of hospitalized patients were discharged to the community (in contrast, only 26 percent of schizophrenics were), but on follow-up averaging 2.6 years, 69 percent were chronically ill, though 31 percent were considered "socially recovered." Retterstol (1970) found on long-term follow-up that 79 percent of his cohort [sic] were self-supporting and 74 percent had had no major periods without work; comparable figures for schizophrenics were 31 percent and 30 percent, respectively. Only 39 percent of delusional disorder patients had been hospitalized since initial discharge and 27 percent were psychotic in follow-up, compared with 90 percent and 80 percent of schizophrenics, respectively. Follow-up studies are consistent in suggesting that 80 to 90 percent of patients with delusional disorder are diagnostically stable over time. It is unlikely, for example, for these patients to develop schizophrenia. Prognostic features have not been systematically studied.

□ AFTERWARD

Substantial progress has been made during the past decade in our understanding of schizophrenia, schizophreniform disorder, and delusional disorder. While the introduction of the *DSM-III* criteria in 1980 narrowed the definition for schizophrenia, thereby creating a more homogeneous group for research, questions remain about whether the narrowing has gone too far. A reemphasis on the importance or the negative symptoms of schizophrenia, or Bleuler's "fundamental" symptoms, has emerged, balancing the perhaps too rigid emphasis on Schneiderian symptoms in the 1970s. Advances in classification and epidemiology have allowed us to reevaluate the distribution of schizophrenia and its risk factors. Despite the drawbacks of the Epidemiologic Catchment Area project, this study has become the model for future community surveys.

The development of new brain imaging techniques such as computerized tomography, magnetic resonance imaging, regional cerebral blood flow, positron emission tomography, and brain electrical activity mapping have enhanced our understanding of schizophrenia. This technology is allowing us to explore the nature and pattern of brain deficits and examine the possibility of symptom localization in schizophrenia. The development of "brain banks" as well as new techniques in histopathology have given renewed emphasis to postmortem research, permitting a more detailed investigation of abnormalities in neurotransmitter systems and in the neuropathology of schizophrenia. While the nosologists and neuroscientists have been clarifying the classification and pathologic mechanisms of schizophrenia, geneticists have been

amassing large family data sets and applying new methods such as gene mapping that promise to enrich the study of genetic factors in schizophrenia.

While technological advances are helping us to explore the etiology of schizophrenia, knowledge about course and outcome has been enhanced through long-term studies. We have also learned that the best treatment approach to schizophrenia combines both pharmacologic and psychosocial measures. Although the pharmacologic treatment of schizophrenia has been hampered by the well-worn dopamine theory, investigators are now looking at other neurotransmitter systems that may yield a more complex interactive model of neurotransmission and thus new pharmacologic approaches. meanwhile, research has highlighted the importance of family interaction models in schizophrenia, leading to more specific psychosocial interventions in the treatment of schizophrenia.

Progress during the coming decade will build upon the foundation of current research. The future appears bright and, one hopes, will lead to a better understanding of the pathophysiology and etiology of schizophrenia. This should eventually allow physicians to offer more to those who suffer from schizophrenia, perhaps psychiatry's greatest scourge.

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EXHIBIT C

Original Paper

Psychopathology 1993;26:90-94

Outcome in Delusional Disorder in Different Periods of Time

Possible Implications for Treatment with Neuroleptics

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Abstract

The effect of neuroleptics in the treatment of schizophrenia is well established. Some reports indicate that at least pimozide may be effective in delusional disorder as well. In this article a long-term follow-up study of 72 first-admitted patients with delusional disorder is described. Outcome in patients admitted during 1946-1948 was compared with that of patients admitted during 1958-1961. We did not find a more favourable outcome in the group admitted after the introduction of neuroleptics. This contradicts our earlier finding for patients with schizophrenic psychoses, indicating that neuroleptics generally may be more effective for schizophrenics than for patients with delusional disorder. Controlled drug trials in delusional disorder are strongly needed.

Several studies have demonstrated the effect of neuroleptics in the treatment of schizophrenics [1]. Recently especially pimozide has also been reported to be beneficial in the treatment of patients with monosymptomatic psychoses, meeting the criteria of delusional disorder according to current classification [2-5]. These patients are, however, often difficult to treat because of denial, projection and reluctance to take drugs. We have earlier reported that some hospitalized patients with delusional order may recover without any specific treatment other than short hospitalization, and some may recover after antidepressive treatment as well [6-8]. In our large sample of patients with delusions as a prominent feature, most patients were admitted after the introduction of neuroleptics, but a relatively large subsample was admitted before the neuroleptic era [9]. For the 141 patients with the diagnosis of schizophrenia or schizophreniform disorder according to DSM-III, it was found that average outcome was more favourable for those patients who were admitted after the introduction of neuroleptics. Moreover, the late clinical course tended to be stable in men, while women on average deteriorated. This is consistent with the hypothesis that estrogen may have postsynaptic antidopaminergic effects like neuroleptics, and protect female patients until age 40-45 [9]. We have also investigated the outcome according to gender in a sample of patients with delusional disorder, where the trend was the opposite as for the schizophrenic patients, namely that female patients did best at the follow-ups, and with the largest difference at last follow-up in the multivariate analysis [10]. The purpose of this study was to examine the difference of outcome between the group of patients with delusional disorder admitted before and after the introduction of neuroleptics.

Material and Methods

The selection of patients and follow-up procedures have been described elsewhere [11-13]. The patients were first-time delusional cases consecutively admitted to the Psychiatric Department, University of Oslo, during 1946-1948 (long-term group) and 1958-1961 (short-term group). Bipolars and patients with confusional states were excluded. One of the authors (N.R.) selected the sample and carried out a personal follow-up in 1963-1964 [11], and another follow-up of the short-term patients in 1966-1967 [12]. About 20 years later the other author (S.O.) personally examined the patients still alive and willing to be interviewed [7, 13]. Diagnosis at discharge from index admission based on the records had been assessed before the last follow-up interviews. Of 301 patients, 71 met Kendler and Tsuang's [14] diagnostic criteria for delusional disorder. These criteria are very similar to those for delusional disorder in DSM-III-R [15], but require an illness onset before age 60. Therefore, an additional patient who developed delusions at age 60 was included, so there were 72 patients, 49 men and 23 women. The mean age at admission was 40 years (range 16-61). The interviews at last follow-up were conducted semistructurally using SADS-L [16] in 42 patients; 24 had died, and 6 patients refused, had moved abroad or were untraceable. Additional information from the Norwegian Central Register for Psychoses, hospital records, family doctors, relatives and death certificates was taken into consideration. The overall psychosocial functioning was estimated using Global Assessment Scale (GAS) [17]. Gas scores were also assessed retrospectively at earlier follow-up (first follow-up in the long-term group and short-term group when insufficient information at second follow-up, otherwise second follow-up). This means that we have GAS scores at 2 points in most patients, at 3-18 (mean 10) year follow-up in the total

sample, and at 22-39 (mean 27) year follow-up in the patients examined at last follow-up. Psychosocial stressor associated with outbreak of psychosis was estimated according to axis IV in DSM-III [18]. The interrater reliability for discharge diagnosis at index hospitalization was estimated based on the same information from the records for 2 raters. The kappa value [19] for Kendler's delusional disorder was 0.86. The reliability of axis IV score was estimated in the same manner, with an intraclass correlation coefficient (ICC) [20] of 0.72. ICC for the GAS ratings was 0.89 at earlier follow-up and 0.87 at last follow-up [13]. Statistical analyses used Student's t test and the x^2 test with Yates correction. Significance was set at 5%.

Results

Table 1 shows that there were no significant differences between the two groups as regards the main delusion at index admission. In more than half of the patients delusions of persecution were predominant, while delusions of jealousy were predominant in nearly one fourth of the sample. Other main delusions were less frequent. Table 2 demonstrates that there were no significant differences between the two groups as to sex distribution, marital status, duration of symptoms at index admission or stressor score associated with outbreak of psychosis. Almost all the short-term patients received neuroleptics during the observation period, while only one fourth of the patients from the long-term group did so, and in these cases later in the course of the illness. During the total observation period long-term patients had taken neuroleptics for a mean of 3.5 years versus mean 8.2 years for the short-term patients. Short-term patients also more likely received antidepressants (43 vs. 6% of cases), but there

was no significant difference as to outcome no matter whether patients had received antidepressants or not (not shown in the table). No statistically significant differences as regard outcome were found between the groups.

Table 1. Main delusion at index admission according to cohort

	Long-term group (admitted 1946-1948)		Short-term group (admitted 1958-1961)	
	n	%	n	%
Persecution	10	56	29	54
Jealousy	4	22	12	22
Reference	2	11	4	7
Hypochondriacal	2	11	3	6
Grandeur	–	0	2	4
Sexual	–	0	2	4
Others	–	0	2	4
Total	18	100	54	101

Table 2. Background variables and GAS score at 10- and 27-year follow-up, mean values or percent of sample

	Long-term (n=18)	Short-term (n=54)	p
Male	72	67	NS
Ever married	71	84	NS
Duration of symptoms, years	1.5	1.6	NS
Axis IV score	3.4	3.3	NS
Neuroleptics ever	25	96	<0.00
GAS score (SD), 10-year	65 (20)	61 (14)	NS
GAS score (SD), 27-year	58 (22)[1]	64 (18)[2]	NS

[1] n=8.
[2] n=34.

Discussion

Contrary to what we found for schizophrenic patients [9], the subsample of patient with delusional disorder admitted in the late fifties and early sixties, after the introduction of neuroleptics, did not show a more favourable outcome than the subsample admitted in the forties. The trend was rather that long-term patients did best at 10-year follow-up. Certainly, the tendency was that short-term patients functioned best at last follow-up, but the long-term group then was very small because of attrition of patients. The results from the last follow-up must therefore be interpreted with caution. Gabriel and Schanda [21] compared the results from their follow-up studies of patients developing a delusional psychoses in midlife, who fell ill before and after the introduction of neuroleptics respectively. They did not find any difference between the two studies as to the frequency of uniform versus polymorphous or episodic versus chronic course. A comparison with our study is difficult because of different methodology and at least partly different diagnostic categories. However, the results of Gabriel and Schanda [21] point in the same direction as ours. A conclusion of our studies is that the late clinical outcome in short-term schizophrenic patients admitted after the introduction of neuroleptics was more favourable than in long-term patients admitted before neuroleptics were available. No such difference was found in patients with delusional disorder. As regards gender differences there was a trend for male schizophrenic patients to do better in the long run than their female counterparts, while in delusional disorder the trend was opposite. A possible explanation could be that neuroleptics generally may be of more important value for schizophrenic patients than for patients with

delusional disorder. Another explanation might be that there are more problems with compliance in delusional disorder than in schizophrenia. Paranoid patients are usually very sensitive to all side effects of drugs, and most reports on the effect of neuroleptics in delusional disorder are still anecdotal. Drug treatment in this disorder, therefore, still seems to be terra incognitia, and controlled drug trials are strongly needed. It also remains to be demonstrated if the effect of pimozide is specific. Because of the difficulties encountered in doing research in this field, trials should be carried out on a multi-centre basis.

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INVOLUNTARY MEDICATION REPORT

USMCFP, Springfield, Missouri	Forensic Study
Institution	Institution Security Level
SELL, Charles Thomas	26864-044
Name of Inmate	Register Number
April 19, 1999	Delusional Disorder, Perscutory Type, Paranoid Personality Disorder, Provisional
Date of Mental Health Commitment	Diagnosis

I. Notice of Hearing:

A. Advance written notice of the hearing was given to the inmate on May 27, 1999 at 9:00 AM
(Date) (Time)
by Dwayne Walker, LCSW.
(Staff Member)

B. The hearing was convened on June 9, 1999 at 12:00.
(Date) (Time)

C. The inmate was advised of his rights at the hearing by Dwayne Walker on May 27, 1999 and
(Staff Member) (Date)
a copy of the notice and advisement form is attached.

II. Staff Representative:

A. Inmate requested staff representative
Michelle Goldberg, Nurse who appeared.
(Name)
Yes __ No XX She was not available.

B. Staff representative Dwayne Walker, LCSW was
(Name)
appointed and appeared.
Yes XX No __

III. Presentation of Evidence:

A. Inmate denies that psychotropic medication is required.

B. Summary of Inmate Statement: "I do not want to take medicine. I do not want my chemistry altered. My brain is working well."

Please see addendum A – copy of Dr. Sell's written statement which he read during The Hearing concerning his beliefs that he, being a dentist in the Army Reserve, was ordered to Brooke Army Medical Center before Waco because the government planned to burn the Branch Davidian Complex and might need him to identify those who died. He also believes that he was sent to Alaska, to be away from the continental United States and not be available to testify. He believes the FBI wants to keep him silent and therefore is persecuting him. These beliefs are interfering with his ability to work with his attorney rationally and to proceed with trial since he is convinced the system is against him. Please note that he writes in the second person, as if he's writing about someone else, frequently a symptom of schizophrenia.

C. Witness:

1. Inmate requested witness: Yes XX No __

2. The following persons were called and appeared.

Thomas Bugel ____ Gordon Lee Baum ____

3. A summary of the testimony of each witness is attached. Yes

4. The following persons requested were not called for the following reason(s).

Walter McGuire – Repetitive
Stephen Sell – No telephone number. See attached.
Brother John DePaul – Had testimony from 1997 trial.
David Baugh – Repetitive
Gerald Martnek – Repetitive
Margery Martnek – Repetitive.
Joan Bystrom – See attached.
Father John Stonisck – Repetitive
Paula Chamberlain – See attached.
Mary Sell – Wife – "No Contact"
Colonel John Roberts – Repetitive
Dr. Abraham Phillips – Repetitive
Rebecca Shrum – Repetitive
Frank Reedy – Repetitive
Dr. Brion – Not found.
Jean Stehle – See attached.

5. Unavailable witness were requested to submit written statements and those statements were considered. Yes XX No __ N/A __

Please see Addendum B – contact with requested witnesses: The Hearing, usually held as early as possible in the stay of an inmate was postponed on several occasions to allow us to contact his requested witnesses and to accommodate the schedule of attorneys who were present. Since this Hearing is an administrative process inside the

Medical Center, we usually have few witnesses requested, and attorneys are not present.

D. Documentary Evidence:

In addition to the notice and advisement form, the following information was considered:

1. Court order committing the inmate for mental health care and treatment.
   Yes XX No __
2. Psychiatric/psychological reports submitted at the commitment hearing.
   Yes XX No __
3. Treatment proposal and justification.
   Yes XX No __
4. Alternative to medication.
   Yes XX No __ N/A __

IV. Findings:

A. The inmate suffers from a mental disorder.
   Yes XX No __

B. The hearing psychiatrist believes that the inmate does require psychotropic medication. Medication is required because the inmate:

1. Is gravely disabled/dangerous to self or others in the institution?
   Yes __ No XX

   He is considered dangerous based on threats and delusions if outside, but not necessarily in prison.

2. Is unable to function in open population?
   Yes __ No XX

3. In order to become competent for trial?
   Yes XX No __
4. Is mentally ill and dangerous, and medication is necessary to treat the mental illness?
   Yes XX No __

V. Specific information relied upon to support findings:

1. Court order for treatment dated April 14, 1999, by Terry I. Alderman, U. S. Magistrate Judge.
2. Psychological Forensic Report dated June 20, 1997, written by Robert Denney, PsyD. This report was prepared with little cooperation from Dr. Sell. Dr. Denney found him competent to return to court.
3. Psychological Forensic Report dated April 7, 1999, by Paul Zohn, M.A. and Richart DeMier, Ph.D. This report found Dr. Sell to be suffering from a Delusional Disorder, Persecutory Type and Paranoid Personality Disorder, provisional. He was found not competent to proceed leading to the current Court Order for treatment. (See section V, 1 above.)
4. Medical records since admission on April 20, 1999. Dr. Sell has functioned in an open unit since admission. He was placed in Competency Restoration Group. On April 22 and April 29, 1999, he participated in the group only showing some cynicism regarding how the "System really works" and "displeasure in his legal representation." On May 6, he participated in the group as he did again on May 27, 1999.

   On June 3, 1999, he became more disruptive to the group, speaking about how "corrupt" the legal system is. Efforts to return to more useful communication failed. "It was decided that he will no

longer attend group until such time as he can behave appropriately."

He remained on Paxil, an antidepressant medication at his request. He is described as being disheveled at times.

5. Past records revealed Dr. Sell had been in Barnes Hospital, St. Louis, in September 1982, with a diagnosis of Schizophrenia treated with Haldol. At that time he was preoccupied with the gold he used for fillings being contaminated by communists.

   In 1997, Dr. Sell stated he discovered the AIDS virus. In October 1997, he was preoccupied with being "followed by the Army, and/or government, FBI and the Pentagon." Currently he is charged with Conspiracy To Commit Murder and Fraud.

6. Hearing: The Hearing was held June 9, 1999, and it was audio taped. Present at the Hearing were Richart DeMier, Ph.D.; Paul Zohn, M.A.; James Wolfson, MD; Dwayne Walker, MSW; Mr. Lawless from Public Defenders Office; Mr. Marcus the Assistant United States Attorney; Dr. Sell; and Dr. Glazzard, Hearing Officer. Dennis Bitz, Medical Center attorney was also present part of the time as were two visiting witnesses, Gordon Lee Baum and Thomas Bugel. Dr. Sell had requested eighteen witnesses, but some could not be located, some gave a written or verbal response and some would have been repetitive. Both Mr. Baum and Mr. Bugel have known Dr. Sell a long time and each from his relationship (Mr. Baum as a friend and civil attorney and Mr. Bugel as friend and former member of St. Louis District School Board) separately stated he knew

of no evidence for Dr. Sell having a mental illness or requiring psychiatric medication.

A packet from Dr. Cloninger, Wallace Renard Professor of Psychiatry at Washington University Medical School in St. Louis, who examined Dr. Sell, contained his diagnosis of Dr. Sell as suffering from a Delusional Disorder and his belief that medication rarely helps a person suffering from a delusional disorder. Dr.'s DeMier and Wolfson and Mr. Zohn presented clinical evidence leading to their diagnosis and reasons for medical treatment.

Their main concern is the persistence of Dr. Sell's belief that the Courts, FBI, and federal government in general are against him, and this preoccupation will interfere with Dr. Sell's capacity to work with his attorney to make rational decisions for himself in court. They believe that Dr. Sell's symptoms point to a diagnosis of Delusional Disorder but also recognize that there well may be an underlying Schizophrenic Process.

Mr. Zohn noted that Dr. Sell believes he invokes spirits of the dead, hears whips cracking and believed that power lines were responsible for his being suicidal. Dr. DeMier noted that Dr. Sell's probable hallucinations and age of onset of his illness suggests a diagnosis of schizophrenia. Delusions can be symptoms of schizophrenia.

Dr. Wolfson stated that Dr. Sell suffers from psychotic symptoms, regardless of the precise illness and that antipsychotic medication is indicated. He said there are no adequate alternatives except electro-convulsive therapy which is not planned and possibly Reserpine, an anti-hypertensive medication with antipsychotic effects but poorly

tolerated side effects. Dr. Wolfson also noted that the early course of Dr. Sell's illness suggested schizophrenia. The record also had suggested use of nitrous oxide a dental anaesthetic which could have caused abnormal behavior. Either schizophrenia with visual hallucinations or a substance such as nitrous oxide could have caused his panic call to police because of Dr. Sell's seeing a leopard in his office, then seeing the leopard getting on a bus and telling police to "shoot me." Dr. Wolfson stated that it is not uncommon to deny hallucinations after arriving at a hospital in order to appear more well. Dr. Wolfson stated that the popular notion that persons with a delusional disorder (not necessarily caused by schizophrenia) do not respond to antipsychotic medications is inaccurate. The "key feature in choosing a therapeutic modality is the symptoms present." (Not necessarily the cause of the symptom.) Dr. Wolfson also noted that Dr. Sell's reasoning is distorted in other ways which interferes with his reality testing as indicated by the following:

> He believes he is still on active duty and that the Geneva Convention should dictate his treatment here, including allowing him to work in the dental clinic. "In reality, persons on active duty would be managed by a parallel military justice system" if his offense had occurred while on active duty.

During the Hearing Dr. Sell defended some of his thoughts, considered by some to be delusional, and persisted in his concerns that the government is against him. He associates his presence in San Antonio at the time of the Waco incident and his later orders to Alaska as related to his being needed in Waco to identify bodies and then

Alaska to remove him from the continental United States so he wouldn't be available to testify against the government. He sees the government as his enemy. Aside from his preoccupation with the government as his enemy, he has been apparently quite successful in the U. S. Army Reserve.

Dr. Sell has been in open population here. The USMCFP is a prison separating its clientele from the public and from other inmates who might be dangerous to each other. Being in open population here does not suggest he would not be dangerous if out of prison. He is charged with Conspiracy to Commit Murder. He is considered a potential danger to others in this context at this time.

Other witnesses who were contacted included Paula Chamberlain who said she had no idea about medicine and suggested calling his wife, and JoAnn Bystrom who stated she has not seen him recently, but said she had not seen signs of mental illness for the past fifteen years. Jean Stehle, Recreational Therapist at the USMCFP, wrote that he occasionally verbalizes grandiose ideations regarding his wealth and abilities but otherwise participated in recreational activities.

Attempts to contact his wife, Mary Sell, brother, Steve Sell, and former psychiatrist, Dr. Brion, were unsuccessful.

Dr. Cloninger saw Dr. Sell for evaluation. His comments regarding diagnosis and treatment are considered. Also, Mr. Lawless, from the Public Defender's Office questioned staff about dangerousness and about the various changes in dates for the Hearing.

Ten witnesses were not contacted at the decision of the Hearing Officer. The ten witnesses are:

Mr. McGuire – a friend and dental patient.
Brother John DePaul – a friend and fellow parishoner.
David Baugh – free lance correspondent.
Gerald Martnek – friend and dental patient.
Mergery Martnek – retired U. S. Army and dental patient.
Father John Stanick – pastor.
John Roberts – director Missouri Medical.
Abraham Phillips – family pediatrician and dental patient.
Rebecca Schrum – friend for forty years.
Frank Reedy – accountant.

These witnesses were not contacted because it is believed their testimony would be repetitive.

7. The large file related to Dr. Sell's career in the U. S. Army Reserve.

VI. Medication Approved: Yes XX No __

VII. Justification for Medication:

Dr. Sell suffers from fixed ideas, not held by others, that do not seem to interfere with his ability to understand the nature and consequences of the proceedings against him but do interfere with his ability to assist his attorney properly in his defense. These fixed ideas, not held by others, are called delusions. Therefore, he has been found incompetent to proceed.

Although Dr. Cloninger has had less success with antipsychotic medications treating a delusional disorder, Dr. Wolfson stated that he has found antipsychotic medication to be a treatment of choice in his experience.

Antipsychotic medication is indicated as the treatment of choice at this time. Because Dr. Sell's delusional thinking also has made him considered dangerous, antipsychotic medication if effective should help relieve him of this problem. Other forms of medication would not treat the primary symptom but could be helpful for other symptoms if the need arose. (For example, antidepressant medications or anti-anxiety medications.) They do not specifically treat delusional symptoms. Other forms of treatment such as seclusion (locked away from others) or restraints (physically held down to prevent danger to others or himself) could be helpful if necessary, but do not specifically treat delusional symptoms. Again, antipsychotic medication is indicated at this time.

VIII. Appeal Rights:

The inmate has been advised of the findings, specific evidence relied upon, medication approval and justification. The inmate has also been advised that he may appeal the medication decision within 24 hours to the Administrator of the Mental Health Division and that the administrator has 24 hours after receipt of the appeal to render a decision. A copy of this report has been given to the inmate. Yes __ No __

IX. /s/ C. D. Glazzard, M.D.
C. D. Glazzard, M.D.
Reviewing Psychiatrist

Delivered to inmate on _____ (Date) at _____ (Time) by

_____ (Staff Member) _____ (Signature) _____ (Printed Name)

INVOLUNTARY MEDICATION
HEARING APPEAL RESPONSE

DATE OF HEARING: 06/09/99

You were afforded all mandated due process rights. Specifically, you were advised of the hearing at least 24 hours prior to the hearing in order to provide you adequate time for preparation. You were afforded the opportunity to select a staff representative who, subsequent to selection, requested to have her name withdrawn due to a work schedule change that caused her to be unavailable at the time of the hearing. As a result, a suitable staff representative with sufficient education and experience was appointed by the Associate Warden (Mental Health). You were afforded the opportunity to select witnesses. You initially requested seventeen witnesses. Six witnesses were deemed to have relevant information regarding the hearing issues and eleven were determined to have merely repetitive evidence. Of those six witnesses who were selected, two could not be reached, two provided phone testimony, and two appeared at the hearing. Before the hearing, you requested an additional staff witness who was approved by the hearing officer. The additional witness you requested provided written testimony. You were afforded the opportunity to be present at the hearing to provide written or verbal evidence in your behalf. You made a verbal statement to the hearing officer and provided additional documentary evidence in the form of a handwritten statement, excerpts from a past trial transcript, and various military documents. Following the hearing, you were provided a written copy of the hearing officer's report.

A review of your medical record and the involuntary medication hearing proceedings clearly indicates that your

attending clinician and the hearing officer independently concluded that you are mentally ill and would benefit from psychotropic medication based on their assessment of data in the medical record, your response to hospitalization, and their interviews with you. The hearing officer's findings that you would benefit from psychotropic medication are based on substantive evidence, namely, the following specific and historic data:

1. An order from a U.S. District Court dated 04/14/99, committing you for treatment to restore competency to stand trial.

2. A pretrial forensic report which formed the basis for the above noted judicial order. That report outlined the opinion of a mental health professional that you were not competent to stand trial due to the presence of a thought disorder characterized by delusions of a persecutory nature involving various governmental officials and agencies, former employees, regulatory agencies, and members of the legal profession. That report also noted that you expressed self-reported atypical experiences commonly associated with mental illness, including hearing things that others are unable to hear and being able to invoke spirits to communicate with the dead.

3. You have a prior history of hospitalization at Barnes Hospital where you were treated with anti-psychotic medication after experiencing apparent delusional beliefs that gold used for fillings had been contaminated by the communists.

4. In the past, you were admitted to Lutheran Hospital after calling the police and reporting that a leopard was in your office.

5. The direct testimony during the hearing from Psychology Intern, Mr. Zohn, and Psychologist DeMier

established that you express delusional beliefs. The referenced delusions include your perceived involvement in the Branch Davidian stand-off and your recurring, but unsubstantiated, belief that the FBI is attempting to discredit you.

6. The testimony from Psychologist DeMier and Psychiatrist Wolfson established that, regardless of the specific diagnostic label, you suffer from a psychotic disorder characterized by delusions of a persecutory nature. The most effective treatment for psychotic symptoms is anti-psychotic medication. In his testimony, Dr. Wolfson clearly stated that, while there may be a clinical difference of opinion regarding the efficacy of medication in treating delusional disorders, the key to clinical decision-making is not the diagnosis, but rather the symptoms. In Dr. Wolfson's opinion, the symptoms of mental illness you exhibit are most likely to respond to treatment if you receive anti-psychotic medication.

Based on the material presented, the hearing officer concluded that:

A. You are suffering from a psychotic disorder which impairs your ability to stand trial.

B. Anti-psychotic medication represents the most likely medical intervention which may ameliorate the symptoms which you exhibit, to the extent that you could be rendered competent to proceed with the charges against you.

C. Other less restrictive interventions such as verbal therapies, activity based therapies, minor tranquilizers, seclusion or physical restraints, in and of themselves, are unlikely to alleviate the delusional symptoms of your psychotic disorder.

D. While you may not represent a significant risk of danger to trained correctional staff inside a prison setting, your current charges of conspiracy to commit murder, coupled with your pervasive belief that you are being targeted for nefarious actions by various governmental, regulatory, and private parties, render you a potential risk to the safety of one or more others in the community.

With reference to the due process procedural issues related to your representation, limitation of witnesses, lack of objectivity by the hearing officer, appropriateness of grounds for decision-making relative to the utilization of psychotropic medication and the role of dangerousness in the decision-making process, the due process hearing was conducted and the decisions were rendered in accord with the provisions in the Code of Federal Regulations, Sections 549.40 through 549.43.

With reference to your due process procedural concerns, the regulation specifies that witnesses "should be called if they have information relevant to the inmate's mental condition and/or need for medication, and if they are reasonably available. Witnesses who only have repetitive information need not be called." The hearing officer properly adhered to these regulations. The hearing officer declined to call witnesses who would present repetitive testimony. Available witnesses were contacted and appeared. Testimony from unavailable witnesses who were above to be contacted was provided through your staff representative. Witnesses who could not be contacted did not testify.

In accordance with the Code of Federal Regulations, the hearing was "conducted by a psychiatrist who is not currently involved in the diagnosis or treatment of the

inmate." The psychiatrist who presided over your hearing fully met that criteria. The presumption of his objectivity and fairness is not automatically undermined by the psychiatrist's supervisory relationship with the psychiatrist who presented evidence at the hearing. You offered no convincing evidence which established that the reviewing psychiatrist was impartial or unfair.

Under the provisions of 28 CFR, Section 549.43, the hearing officer "shall determine whether treatment or psychotropic medication is necessary in order to make the inmate competent for trial or is necessary because the inmate is dangerous to self or others, is gravely disabled, or unable to function in open population of a mental health referral center or a regular institution." This language succinctly addresses both your concerns about the basis for due process decision-making and the role of dangerousness. The language clearly indicates that restoration of competency is a criteria independent from the other specified criteria set forth in the regulation. The decision of the hearing officer was also based on specific evidence, (your delusional beliefs with respect to various agencies, departments, and individuals). In short, the hearing officer's findings were not arbitrary or capricious, but were based upon specific evidence presented by witnesses who evaluated your condition and who have the added responsibility for planning a course of treatment for you.

Even if your dangerousness to others was a decisional component for the administration of antipsychotic medication that was causally linked with the substantive criteria of restoration to competency, the evidence presented at the hearing regarding your potential danger and risk to the safety of others meets such a requirement. Specifically, your pending charges of conspiracy to commit murder

coupled with evidence that you experience delusions of persecution at the hands of various unnamed individuals and agencies, renders you a potential risk to others in the community.

Based on the above, the hearing officer's decision that you would benefit from the utilization of anti-psychotic medication is hereby upheld.

7/2/99	8 35 AM	/s/ [Illegible]
(Date)	(Time)	(Signature)

No. 02-5664

(6)

DEC 17 2002

OFFICE OF THE CLERK

In The
Supreme Court of the United States

CHARLES THOMAS SELL, D.D.S.,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX
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Petition For Certiorari Filed August 2, 2002
Certiorari Granted November 4, 2002

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

St. Louis Missouri
September 29, 1999
9:10 a.m.

vs. Cause No. 4:97CR290 (DJS)
4:98CR177 (DJS)

CHARLES SELL,

Defendant,

TRANSCRIPT OF THE EVIDENTIARY HEARING
RE: INVOLUNTARILY PSYCHIATRIC
TREATMENT AND MEDICATION
BEFORE THE HONORABLE TERRY I. ADELMAN
UNITED STATES MAGISTRATE JUDGE

TRANSCRIPT ORDERED BY: Lee T. Lawless

APPEARANCES:

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Recorded By: Karen Moore,
Court Reporter

Transcribed By: Carter Transcription & Reporting Company

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[3] (Opening of the Court 9:10 a.m.)

THE COURT: We are here today based on the Defendant's motion that the Court conduct a judicial

hearing regarding the propriety and advocacy of the involuntary administration of medication and other treatment to Dr. Sell. I granted that motion, and that is the purpose of our hearing here today. In that regard I would like the record to show that, Dr. Sell is here in the courtroom with his attorneys, Mr. Barry Short and Mr. Lee Lawless. Mr. Mark Light. The Government is here represented by Mr. Howard Marcus and Ms. Dorothy McMurtry. Mr. Marcus, Ms. McMurtry, Mr. Lawless, Mr. Short, are you all prepared to proceed on this matter?

MR. SHORT: We are, your Honor.

MR. MARCUS: Yes, your Honor.

THE COURT: All right then. Mr. Marcus the way I read the case is, it is your burden to show the need for, – the involuntary medication and therefore would ask you to proceed.

MR. MARCUS: Yes, your Honor, before we proceed I just wanted to confirm one thing for Mr. Lawless, my understanding, from our conversation yesterday that you would stipulate to their expertise as witnesses. Is that still in effect?

[4] MR. LAWLESS: Yes, that they, – I'd probably would like a copy of their, –

MR. MARCUS: Mr. Short has a copy, –

MR. LAWLESS: Get me one too, to put into the record.

MR. MARCUS: Okay.

MR. LAWLESS: But, we are not going to contest it, – testify his expert witnesses.

MR. MARCUS: Your Honor, at this time I would call Dr. Richart DeMier.

MR. LAWLESS: I'd like to invoke the rule to exclude witnesses.

THE COURT: Okay.

RICHART DEMIER, GOVERNMENT'S WITNESS, SWORN

MR. MARCUS: May I proceed?

THE COURT: You may proceed.

DIRECT EXAMINATION

BY MR. MARCUS:

Q All right, Mr. DeMier I'm going to hand you what has been marked Government's Exhibit 2 which is a, – we would ask you to identify this for us please?

A Yes. That's my Curriculum Vitae, which describes my education and clinical experience.

MR. MARCUS: I would like to offer Government's Exhibit 2 in evidence at this time.

[5] THE COURT: Any objection?

MR. SHORT: No.

THE COURT: May be so admitted. Thank you.

BY MR. MARCUS:

Q All right, Dr. DeMier, what is your occupation?

A I'm a Clinical Psychologist.

Q And, by whom are you employed?

A I'm employed by the U.S. Medical Center for Federal Prisoner's.

Q And how long have you been there?

A I've worked at that institution four or five years.

Q Okay. Dr. DeMier in your capacity, at the Medical Center in Springfield, have you had an opportunity to have contact with Dr. Sell?

A Yes, I have.

Q And what would be your role as to Dr. Sell in the institution?

A I evaluated Dr. Sell when he was admitted for an evaluation of competency, that evaluation occurred between February 24th and March 25th of this year. I have also worked with him since his return to our institution on April 20th of this year, when he was committed for competency restoration treatment.

Q And when he was committed initially and now you have been his attending clinical?

[6] A That's correct.

Q Any you knew that the mental health evaluation was done, was that done with you along with an Intern?

A That's correct.

Q And you did intake interviews?

A Yes.

Q And, in addition to structured things such as that, and psychological testing, have you had contact with him on an everyday basis, or every other day basis?

A During his original evaluation, I had contact with him, probably every business day.

Q Okay.

A Since he's been back for competency restoration treatment, I've had frequent contact with him. Both on his living unit and more formal individual interviews.

Q Now, Dr. DeMier, in addition to this type of contact with him, as the attending clinician, do you also do contacts with the, – medical center staff with Dr. Sell?

A Yes, I do.

Q And would this include psychiatric nurses as well as some of the trained correctional officers?

A That's correct.

Q And what would be the need to do that for?

A During evaluation and treatment of this type, I [7] think it's very important to rely on multiple sources of information. The observations of the correctional officers, who have training and working with our mental health population and the observations of the psychiatric nurses, just provides more information than I might get simply by my own interactions. It's not uncommon that defendants will present differently when they are around their doctor than they do when they around other individuals.

Q Okay, Dr. DeMier, as we indicated earlier, you and an Intern were involved in the original mental health evaluation, would it be correct?

A That's correct.

Q And the intern signed off and you signed off on this also?

A That's right. We authored the report together.

Q And at that time based on your experience and training, you had an expert opinion that he was suffering from a disillusion disorder, and incompetent to stand trial?

A That's correct.

Q And specifically, what type of delusion disorder did you diagnose?

A He was diagnosed with Delusional Disorder Prosecutorial Type.

[8] Q And as such, do you consider him psychotic?

A Yes.

Q And you currently consider him psychotic?

A That's correct.

Q And can you explain to the Court what you mean by psychotic?

A Psychotic means that the person has significant impairments in their contact with reality. In the present case, or with anybody with prosecutorial delusions, they have fixed false beliefs, – beliefs that are not in contact with reality, but that are firmly held even in the face of evidence to the contrary. People with prosecutorial delusions

generally feel that they are being threatened or harassed in some way, and have a tendency to misinterpret neutral stimuli or benign events as something bivalent or threatening are specifically directed at them.

Q And based on your training and experience, in the setting that you are in, what is the appropriate treatment for psychosis?

A I believe that psychosis is best treated with antipsychotic medications.

Q And if Dr. Sell is not provided with medication in your expert opinion, what do you believe will occur?

A I believe that he, – his condition will continue [9] to deteriorate.

Q And are there any long term harms in that?

A There are a couple of very important long term harms in that. Some of these, scientific literature indicates that, delaying treatment for somebody who is sick has two adverse effects. The first is once treatment is initiated it's likely to take a longer time before the person gets better. In other words, the longer they are sick prior to the beginning of treatment, the longer it will take the treatment to work. The second important adverse effect is that some of the literature suggests that, when treatment is delayed, the ultimate outcome, the person's optimal response to treatment maybe diminished.

Q And you believe that to be the case here?

A Yes, I have no reason to believe that his course would be any different.

Q Now, since Dr. Sell's hearing in June of 1999, down at the Medical Center, has there been any change in his behavior situation?

A Yes, there has.

Q And in June of 1999, what was his status in terms of where he was being held at the Medical Center?

A In June 1999, he was housed on an unlocked living unit. Which means he had a single cell, – he had no [10] cell mate, but his cell door was unlocked from around six or six-thirty in the morning until about ten at night. He was able to move around our fairly large institution, go up to the main dining hall for meals, go to the recreation area, – he had a lot of freedom within the boundaries and guidelines of the type of facility we are.

Q And since June of '99, have you seen any deterioration in his mental health?

A Yes, we have.

Q And, – as we stand, he is without medication?

A That's correct. He's without anti-psychotic, –

Q Anti-psychotic, –

A medication.

Q And has he made any comments to you that would be in line with this deterioration?

A He has made numerous comments that indicate that his judgement remains poor and getting even poorer.

Q Can you elaborate on some of the comments that he has made to you?

A Yes. He told me recently that I should be prepared to testify in front of Congress, about my conduct in this case, and the way that, – about my conduct in this case, because he asserted that the way his case is being handled will prevent truths from being revealed about [11] the FBI involvement, – involvement of other law enforcement at the Branch Davidian Complex in Waco, Texas.

Q Has he talked to you about his role concerning the Geneva Convention?

A He stated that, as a member of the Geneva, – because of the Geneva Convention, he should be allowed to practice as a dentist within our facility.

Q Have you had any conversations about Bosnia, and the need for him to go to Bosnia?

A Yes. This probably predated the hearing in June, but when the U.S. Military initially became involved in the Bosnia conflict, Dr. Sell stated that he expected the U.S. Military to come to our facility to secure his release so he could go to Bosnia. When he was told that that was not likely to happen, he expressed some delusional beliefs that his presence in Bosnia was absolutely essential to the safety of our troops, and if he weren't permitted to go that would mean that it, to use his words, – somebody wanted a lot of American boys dead.

Q Now, since the June of '99 conversations, have you had any conversations concerning his fear of what the FBI would do to him if moved to a local facility?

A Yes. He continues to harbor beliefs that if he [12] were moved to a County Jail, the FBI would have him killed.

Q Has he made any comments in terms of how he views the government?

A It was reported by another staff member that he had referred to the Federal Government as the Anti-Christ.

Q Now, specifically in terms of change of behavior, are you familiar with an incident or series of incidents, centering around a female nurse at the medical center?

A Yes, I am.

Q And can you tell me how this began?

A Dr. Sell apparently, or evidently, began to form an inappropriate relationship with a nurse on staff at our facility. He was inappropriately familiar with her, calling her by her first name, making statements that indicated that he believed they had some sort of special relationship, –

Q At, –

A – those statements persisted; even after he was told repeatedly that they weren't appropriate.

Q At some point in time did he confront the nurse, with the fact he thought they had a special relationship?

A He told her, words to the effect that, you know, – [13] "Why don't you think I'm special anymore"?

Q And who directed him to cease and desist in this conduct?

A That particular nurse explained why the conduct was inappropriate and that it wouldn't be tolerated.

Q And did the conduct continue?

A Yes, it did.

Q Ultimately, as a result of this conduct and escalating conduct, was he placed in a lock-down facility?

A He was moved to a more secure unit of our facility, yes.

Q And did he offer any explanation as to why he believed he was moved, or did he make comments to any staff why he was in this more secure scenario?

A I think it's likely that he misinterpreted the reasons for his move, which were initially disciplinary in nature.

Q And has he ever made the statement, "I was messing with the nurse"?

A Yes, he did tell one of our correctional officers that.

Q And did he elaborate on that, as to physical or non-physical contact?

A Yes he did. He said words to the effect that, [14] "I have never touched her, but I would if she asked me to".

Q Did he ever express any feelings towards her?

A He has expressed love towards her.

Q Okay. And when told this wasn't appropriate, what was his response?

A He said, "I can't help it," he made that statement to the nurse himself.

Q Now, has he ever made comments to any staff members concerning smelling the nurse's presence?

A He did report that to staff members.

Q As a result of this conduct, in this institutional setting, what was the nurse's response?

A She wrote a disciplinary report. We call it an incident reports in the Bureau of Prisons, – which basically accused him of being inappropriate, insubordinate and refusing to follow an order, the order being to cease the behavior.

Q In light of conduct and his history, did the nurse feel threatened?

A I believe that she did.

Q And as a result he was moved into this more secure environment?

A That's correct.

Q Can you describe for the Court the secure [15] environment he was moved into after this series of incidents with the nurse?

A He was moved to a unit where he is maintained in a single cell, that is without cell-mates. The cell door is locked continuously. He is allowed to shower every other day. He's allowed out of his cell for recreation, for an hour a day, five times a week. It's a very restrictive setting. Before his cell door can be opened he cuffed, – he is handcuffed through a slot in the door. Doors on that unit, not just for Dr. Sell, – but for anybody on that unit, the door cannot be opened by policy without three staff members on

the unit. He is, – he receives a pat search whenever he leaves his cell.

Q Now, based on his history and in the contact in the series of events with this nurse, were there concerns that he was forming another form of a delusion?

A There are concerns that he was developing a delusion of the erotomania type.

Q And what is that?

A That is a delusion that a person is in love with, with a patient, usually a person of higher status.

Q And given his history and this series of behaviors, in your opinion does this present a risk of danger?

A Yes, especially given his history, and the recent behaviors, we thought that the risk to others was [16] becoming much more immediate.

Q In looking at his history you were familiar with and incident involving Dr. Sell spitting on a magistrate?

A I am familiar with that.

Q And you are familiar with the charges in the pending case?

A Yes, I am.

Q And that would include a plot to murder a Federal Agent as well as a government witness?

A Yes, I am familiar with that.

Q And you are familiar with his history in the other county jails he was held in pending trial in this matter?

A Yes, I understand that his behavior was very disruptive in other settings.

Q So these are all factors that go into your considerations in light of his recent conduct?

A That's correct.

Q Now, you talked again about this incident with the nurse. Does this reflect a general trend in terms of how he's dealing with the staff down there?

A I think it reflects a general gradual deterioration in his clinical condition.

Q And would this be responses that are inappropriate, [17] but are more personal and directed?

A That's right, whereas previously his focus of his delusions have been on larger entities or larger issues, he appears to becoming more focused on a personal basis, he becomes, – his statements and thoughts become directed at this nurse or he told me that I would personally have to appear before Congress. So, his focus, – the focus of his delusional beliefs is becoming more immediate.

Q And this would be changes you perceived since June of 1999?

A That's correct.

Q Now, you noted the poor judgement in the directed and personal actions, do you see any cognitive slippage occurring?

A I think that is all reflected in cognitive slippage.

Q Okay. Given his history which you've eluded to in the series of events that have occurred since June of 1999,

do you have an opinion as to whether Dr. Sell himself is dangerous?

A Yes, I do.

Q And what is that?

A I believe that he is dangerous at this time.

Q And Springfield Medical Center is attempting to [18] deal with this as best they can by extreme restrictive settings?

A Well, I think that we are able to maintain the safety of our staff and of other patients, and of Dr. Sell himself, by keeping him in our most restrictive setting.

Q This is an extreme setting you have him in at this time?

A It's among the most secure settings in the Federal Bureau of Prisons.

Q Now, in terms of his behavior, are there any concerns in terms of a concept called Threat Control Override?

A Yes, there are.

Q Can you explain it to the court please?

A Yes, Threat Control Override, is a fairly recent theory regarding dangerousness in mental illness. For many years there was clinical lore that people that have mental illness are at increased risk of dangerousness. Further research tended to indicate that, that was not the case, that people with mental illness are not at increased risk simply because they have mental illness. In the last several years we've, we as a field, have accomplished more

precise research, and have identified a couple of areas where people do appear to be at [19] increased risk due to their mental illness. One of those areas is a person with a psychotic disorder, that has persecutory features. The term "Threat Control Override," comes from the idea that when a person perceives threats based on their persecutory delusions, their perceived threats, their perceiving to protect themselves may override their behavioral controls. In other words, a person with a persecutory delusion may perceive that he is a danger or at risk, when there is, in fact, no risk, but because of that perception he may act out in a way to defend himself or to strike first, to protect himself from this perceived but, in fact, nonexistent danger.

Q In light of some of the more direct and personal material he has related to you concerning the FBI, do you believe this to be a problem now?

A I think he is an increased risk for behaving in such a manner.

Q When you say increased risk you mean for immediate violence?

A That's correct.

Q Now, in your experience as a clinician have you been involved in the treatment of any patients suffering from delusional disorder?

A I have treated two patients, – I've been involved [20] in the treatment and care of two patients diagnosed with delusional disorder frequency.

Q In delusional disorder, is somewhat of a rare diagnoses?

A Yes, it is fairly infrequent.

Q And it would have been a new diagnosis since 1987?

A That's correct.

Q And, in the two that you have seen, – now as a psychologist, you cannot prescribe medicine, but you were involved in the treatment and you saw how the medicine was prescribed and worked?

A That's correct.

Q What was the treatment that was used in these two gentlemen?

A In both cases the patients were prescribed anti-psychotic medications.

Q And do you recall which medications in these two cases?

A One patient was prescribed Haldol, the other was prescribed Olanzapine.

Q And these are both anti-psychotics?

A Yes, they are.

Q And in the two cases were you able to restore to competency either of the two?

A Yes.

[21] Q And which, – how many of the two?

A One of the patients was restored to competency.

Q And the other patient who was not restored to competency, what was the effect of the medication?

A There was a significant improvement in his clinical condition, even though it remained the opinion of the staff that he had not been restored to competency.

Q All right sir, based upon your training and your experience, would your expert opinion, what would it be concerning the use of anti-psychotic medication as to Dr. Sell?

A I think anti-psychotic medication is clearly indicated, as it is the only treatment that we could reasonably expect to improve his condition.

Q And in your opinion what would be the effect of the anti-psychotic medication on either the issue of violence or the risk of violence or danger?

A If he responds to, – if he has a therapeutic response to medication, I would expect those risks to significantly decrease.

Q And what is your opinion as to the effects in terms of restoring him to competence?

A I believe that he can be restored to competency, as a result of treatment with anti-psychotic medications.

MR. MARCUS: Can you give me just a moment Judge?

[22] THE COURT: Yes.

(Pause)

MR. MARCUS: That's all I have at this time Judge.

THE COURT: Mr. Lawless or Mr. Short whoever is going to do it, whenever, – you can take your time to do it.

MR. SHORT: Good morning, sir.

THE COURT: Good morning.

CROSS EXAMINATION

BY MR. SHORT:

Q Let me ask you, this, Dr. DeMier, since June of 1999, have you been the primary clinician for Dr. Sell?

A Yes, I have.

Q And, since June of 1999, how have you treated him, for the illness that he suffers?

A Since June of 1999, I really have not been able to provide treatment for the illness that he suffers.

Q Other than wanting to give him anti-psychotic medication, what have you done to treat his symptoms?

A I don't believe there is any other effective method of treating the symptoms at this time.

Q Explain to the Court in a little more detail, what is persecutory delusion? Particularly, the type that Dr. Sell suffers.

[23] A A prosecutorial delusion is false belief that's deeply ingrained, the person absolutely believes, the delusions, absolutely believes that what he is thinking is true and accurate. The prosecutorial delusions generally involve themes of being threatened, being harassed, being persecuted or being placed in danger and the person will

hold these beliefs, even in the face of compelling, contradictory evidence. Another important feature of these delusions, is that the persons experience, – the world, – their experience, their environment, is tailored to be consistent with those delusional beliefs. People with this illness will often mis-perceive things, so that they fit into this delusional system. New material is often incorporated into the delusion as time goes on.

Q Would you agree that Dr. Sell specifically has great mistrust for the United States Government?

A Yes, I believe so.

Q And would you agree with me that his distrust probably extends to the Springfield Medical Center?

A I don't know that, but it certainly would be reasonable.

Q Would you say that it is, – that in treatment of persons with the disorder of Dr. Sell's, that as a clinician you would want to gain his trust, or cause him [24] to mistrust you?

A I would prefer to gain his trust.

Q He is put down, – has been put in a more secure environment, you said since June?

A That's correct.

Q And as you later said in your testimony, is as secure as you can get at Springfield Medical Center, correct?

A That's correct.

Q So, because he had an "inappropriate" relationship, which as you described, was nothing other than comments, he has been placed in an environment, similar to one if someone had murdered somebody at Springfield, correct?

A Well, I can't agree with, – the proposition that it was nothing other than comments. I think that we have to attend to the thought patterns, and whether it was, –

Q If he had killed the nurse, he wouldn't have been any worse off than he is now would he?

A Well, I think he would be worse off, he wouldn't be in a different setting.

Q He'd be in the same setting wouldn't he?

A Actually, that may not be true, if he had killed the nurse, he may have been moved to another building.

Q If he'd stayed there, he'd been no worse off?

[25] A He wouldn't have been placed in a different setting.

Q So you have treated Dr. Sell, you being the Springfield Medical Center, as if he had committed the worst of crimes and remained in the Medical Springfield Center, correct?

A I don't, – I don't really think that I can predict what would happen if he had killed a staff member, I've never seen, – seen how we would respond to that.

Q Do you think his treatment now has caused, – strike that. Do you think this secure environment which

he's placed has caused him to trust the government more or trust the government less?

A I don't know that it has had any affect, because of the degree of his distrust for the government from the outset.

Q That certainly wouldn't cause him to trust the Springfield Medical Center more, would it? To be treated just as anybody, – if they'd committed murder had been treated in that facility.

MR. MARCUS: I am going to object to the form of questioning, it's argumentative.

THE COURT: Okay. It will be sustained as to the form.

BY MR. SHORT:

[26] Q He's in lock down?

A He's on a unit called 10E, he's locked down as a colloquial term.

Q It's a euphemism really for a solitary, isn't it, you're locked in period, except for one hour, – what did you say, – how many times does he get out of that cell?

A He's released from the cell, five times a week for an hour of recreation, he's offered a shower every other day; he is released from his cell for medical reasons, interviews, and if he would need an x-ray or dental appointment, or something like that, – of course he would be escorted to that.

Q Do you think that's the situation, – that situation you just described is helping, or harming his mental condition?

A I don't have evidence that it's helping or harming, his mental condition, –

Q It certainly isn't helping is it?

MR. MARCUS: I want to object again, it's argumentative.

THE COURT: I'll allow it, go ahead.

BY MR. SHORT:

Q Would you say that, – being in that situation is helping his mental condition at the moment?

[27] A I think that, keeping him safe from harm, and keeping others safe from harm, is beneficial for him, whether he perceives it as helpful or not.

Q Is that cell cold when it shouldn't be cold?

A Not that I'm aware of.

Q Does it have bugs in it?

A Not that I'm aware of.

Q Is he getting all his legal material as Judge Adelman ordered?

A His legal material is stored on that unit and he can request access to documents within that material. There is by policy, a limit on the amount of, – the amount of legal material that inmates can have, or defendants can have in those particular cells.

Q He doesn't have access to his legal material, without asking for it, does he?

A That's correct.

Q And when he asks for it, it's not necessarily given to him, is it?

A I doubt that it is given to him immediately, I assume that it is provided when he asks for it.

Q But, you don't know one way or the other?

A I know he has complained of not receiving it in a timely manner.

Q And he's right, isn't he?

[28] A I don't have a reason to disbelieve him.

Q Is he even furnished with a writing instrument?

A Yes, he is.

Q How often?

A Supplies, which include pencils are passed on a daily basis.

Q Does he have one in his cell to use anytime he wants to?

A I assume so.

Q But you don't know one way or the other?

A Well, I know he's given the opportunity to have a pencil in his cell, he's swapped out a pencil daily.

Q Now, let's talk about dangerousness a little bit. He was in the, – he did have relative freedom of movement as you described prior to June, did he not?

A That's correct.

Q And, he never caused any danger, to any person before that time, did he?

A No.

Q There were no reports of him being a danger to either staff or other, – other inmates, prior to June, was there?

A No.

Q He never harmed anyone?

A No.

[29] Q Never threatened to harm anyone?

A Not that I'm aware of.

Q And, physically didn't harm this nurse, did he?

A No, he did not.

Q He didn't threatened to harm her, did he?

A No.

Q How many inmates in open population down there, would probably say about a nurse, "If she had welcomed my advances"? I would be more than happy to make advances'. How many people do you think would say that down there, – males? All of them?

A I don't have any basis for estimating how many would respond to that.

Q Do you find that particularly unusual, in that, – jail type setting, with a male, – if you said, "If a nurse would welcome his advances, he might make them"?

A I think it is unusual.

Q But he didn't make them, did he?

A I'm not sure I follow the question.

Q In any event, when is the plan on letting him out of that secure environment?

A My plan is to let him out of the secure environment when his mental state improves to the point that we can do so safely.

Q What you are really saying is, you are not going to [30] let him out if he doesn't take the anti-psychotic medicine?

A I'm not, – given his current mental status, I don't think it would be safe to let him out, and I see anti-psychotic medication as the only effective means to improve his mental state, so that we can give him that freedom.

Q Now, you said that you had experience with two patients, is that correct, – that had a delusional disorder?

A That's correct.

Q And one was treated with Haldol, and one was treated with Olanzapine?

A That's correct.

Q One had restored competence, and one did not have restored competence, but had a recovery of sorts?

A There is significant improvement in his condition, I think it would fall short of what we consider recovery.

Q Which one, – what drug was used on the one that was restored to competence, in your opinion?

A Haldol.

Q Haldol. Is that your recommendation, – I understand that you cannot prescribe it, – but when you, – your recommendation that Dr. Sell be given [31] Haldol?

A I would not recommend one agent over another, I just don't have the, expertise.

Q Are you aware of the side effects of Haldol or Olanzapine?

A Yes, I am.

Q Pretty significant, aren't they?

A I'd be hesitant to say, – I would concede that they are significant, as long as it's recognized that there has to be a cost benefit analysis. There are potentially significant side effects, but there's also potentially, very significant recovery from symptoms.

Q Are both those drugs called neuroleptics?

A Yes.

Q Typical, neuroleptics?

A Haldol is a typical neuroleptic, Olanzapine in is a class of atypical anti-psychotic medications to another class of medication.

Q Have you ever looked at the *PDR, Physicians Desk Reference*, to the precautions and counter indications, dealing with Haldol and Olanzapine?

A Yes, I have looked at those.

Q What's Tardive Dyskinesia, D-Y-S-K-I-N-E-S-I-A?

A Tardive Dyskinesia is a condition, characterized by abnormal motor movements, which are involuntary. It's [32] believed to be caused by long term exposure to certain medications, especially the anti-psychotic medications that are not termed atypical. That is not, – not this new class. But, it's a permanent condition which involves, abnormal motor movements, basically or typically in the face, which can be a – very prominent, the person can't control without sustained attention to it. In other words, the person can control the motor movements for a huge area for a few moments, but can't do so, on an extended basis, –

Q Now, as you said, – I'm sorry, I interrupted you.

A – as soon as they stop trying, the involuntary movements return.

Q As you said it's permanent, it's irreversible?

A That's my understanding.

Q So, the cost benefit there is, if one were to unfortunately undergo this, – side effect, is that one might be rendered competent in your opinion, but have a permanent, tardive dyskinesia?

A If the person were on one of the medications that's been associated with that for a long enough time, and if they were one of the sub-group of people on that medication, that developed the condition, then, yes, that is a risk.

Q Is Neuroleptic Malignant Syndrome, a counter [33] indication for Haldol?

A I don't believe it's a counter indication, it's a very rare side effect, it's significant and should be attended to, but I don't think the mere presence, or the mere fact that, that syndrome exists counter indicates the use of the medication.

Q Is Neuroleptic Malignant Syndrome a potentially fatal symptom, complex?

A Yes, it is.

Q Let me just hand you what's, – I'm going to need to mark the *Physician's Desk Reference, PDR 1999*. Turn to page, – direct you to page 2190, including Haldol, and under the counter indications and after discussing tardive dyskinesia, there is a warning, what is the next section?

A Neuroleptic Malignant Syndrome.

Q Would you agree that there's been a number of cases of branchial pneumonia, fatal, following the use of Haldol? Or do you know?

A I really don't know.

Q What was the other drug, – Olanzapine?

A Olanzapine, O-L-A-N-Z-A-P-I-N-E.

Q I got it here. Neuroleptic Malignant Syndrome, that we just talked about with respect to Haldol, a counter indication of Olanzapine, or do you know?

[34] A I believe that I misunderstood your, – words, – use of the word counter indications previously. And, –

Q Or just a warning, is it a warning?

A I believe it's listed in the, –

Q Counter indication probably is the wrong the term, it's a warning isn't it?

A Yes.

Q Have seizures occurred in people that have taken Olanzapine?

A I don't know.

Q Do you know what all the side effects, or warnings, or problems, and side effects can develop from taking Olanzapine?

A I know the more common ones, I know the ones that our psychiatrist, at our facility, generally discuss with people when taking the form consent. I do not know the exhaustive list of everything that's written for them.

Q So, as the situation exists right now, Dr. Sell is getting no treatment, correct?

A I think that's a fair statement.

Q And, he is going to remain, subject to Judge Adelman's orders on time, he's going to remain in that solitary confinement, until he agrees to take anti-psychotic medicine, right?

[35] A Not necessarily. If his condition improves spontaneously, which I think is very unlikely, but if that happens, – you know, – we're going to make our decisions, about where to keep him, based on his clinical presentation and his behavior, not whether or not he is taking medication. Unfortunately, I think that the medication is

going to be necessary, before we see improvements in his behavior.

Q Do you have a recommendation as to what drug he should be given?

A No, I do not.

Q How many of the anti-psychotic drugs can be given by injection?

A There are several, I don't know the exact number.

Q That's all I have for now.

THE COURT: Any redirect.

MR. MARCUS: No redirect

THE COURT: Okay, you may be excused, Dr. DeMier. Excuse, me, I'm sorry Mr. Lawless, – I apologize, okay. I didn't realize we were going to do this separately, so, go ahead,

MR. LAWLESS: Thank you.

THE COURT: In the past sometimes you've done it all.

MR. LAWLESS: That's all right, thank you.

[36] CROSS EXAMINATION

BY MR. LAWLESS:

Q Dr. DeMier, as I understand it from looking at your Curriculum vitae, you've graduated with a PhD. in May of '94, is that right?

A That's correct.

Q Okay. And since that time, has all of your employment been at the Federal Medical Center?

A Yes, it has.

Q So, you've never been involved in private practice?

A Actually, I do teach a course at a local university, one night a week

Q Okay. Do you see patients privately?

A No, I do not.

Q And so, from '94 to the present, the Federal Medical Center is the only place where you have been practicing your profession, as I understand it?

A That's correct.

Q Okay. Do you have what would kindly be referred to as a caseload there?

A Yes.

Q Okay. And what's your current caseload?

A Currently, my caseload is approximately, fourteen patients.

Q Okay. And are some of those for purposes of [37] competency examinations?

A (No verbal response.)

Q There's not yet been a determination, by a court as to whether or not they are competent, to stand trial?

A Yes, some of them are for court ordered evaluations of competency.

Q Okay. How many of those fourteen?

A At the present time, the number is fairly low, because my duties at the institution have changed somewhat.

Q What are your duties?

A On the mental health evaluation service, we have four psychologists, and a psychiatrist who do mental health evaluations, and most of the time we work with court ordered evaluations. But on a rotating basis, for a six month periods, one person is assigned to evaluate patients who are convicted prisoners sent from other facilities, and at the beginning of September, I started evaluating convicted prisoners, who were sent from other facilities to see whether they need inpatient treatment. So that has significantly reduced the number of forensic examinations that I have done. The cases I have remaining, are in their final stages.

Q Dr. Sell is not a convicted prisoner?

A No, he's not.

[38] Q The convicted prisoners that you're seeing, are they on 10E?

A Some of them are.

Q How many?

A Of the one's that I'm seeing?

Q Yes.

A Two of the three convicted prisoners I am currently seeing are on 10E.

Q Okay. I'm sorry, I misunderstood when you said you saw fourteen, I thought you said that the majority of those now were convicted prisoners, is that not the case?

A The majority of the fourteen, of my current caseload are either competency restoration cases, –

Q How many are those?

A About six.

Q Okay. And Dr. Sell would be one of those?

A That's correct.

Q And the other five, are you treating them with anti-psychotic medication?

A I'm sorry, the other five?

Q Yes, well, Dr. Sell is one of them, the other five?

A I believe all, except for one, are being treated with anti-psychotic medication.

Q All right. What's the current population at the [39] Federal Medical Center?

A It's approximately eleven hundred, I don't have an exact figure.

Q And what is considered the design capacity, for that institution?

A I believe, the design capacity is nine hundred and twenty-five, – I'm pretty confident it's in the nine hundreds, – nine twenty-five is the number that I recall. It may not be accurate.

Q So, there's approximately two hundred over capacity?

A I think that's about right.

Q All right. Now, you said that, – your testimony on direct, was I think that initially, during the competency examination period, you had fairly regular contact with Dr. Sell, what has your contact been since the determination by the Court, that he was not competent?

A It's been less frequent.

Q When was the last time you saw him?

A Last time I interviewed Dr. Sell was, – I believe it was last Thursday, it was approximately a week, to a week and a half ago.

Q And was that interview with Dr. Wilson?

A Yes, it was.

[40] Q Where did that take place?

A That took place in an interview room, on the 10E living unit.

Q What was the purpose of that?

A We both wanted to, –

Q You be, being, – both being, Wilson and yourself?

A Dr. Wilson and my both wanting to interview him, shortly before, this appearance, to be certain that there hadn't been any significant changes in his mental state. I hadn't noted any during the rounds, but I felt it was appropriate to spend a little bit more time with him, so

we're sure of accurate information presented before the Court.

Q Okay. And how long did that session last?

A Approximately an hour.

Q Prior to that session, when was the last time you had seen him?

A I believe that I saw him during unit rounds on Tuesday, of last week.

Q What does unit rounds consist of?

A Basically, that's going door to door, and, – for my patients, just touching base with them, talking briefly, seeing if they have concerns. It also consists of reviewing their record and talking to unit staff, the officers that work on the unit, the psychiatric nurses, [41] to see if there is any evidence of significant changes in their clinical status.

Q How often do you make unit rounds?

A At least weekly, usually two or three times a week.

Q And how long a period of time do you typically devote to unit rounds?

A It varies, based on the number of patients that I have on that unit, –

Q Why don't you give me the range?

A Anywhere from five to, – five minutes, to a half an hour.

Q Per patient, or a total?

A Yes, that's a total.

Q The total time that you would spend making unit rounds would be somewhere between five minutes and half an hour, for all of your patients?

A Yes. And if there was a need to talk to somebody at more length, I would ask the officer to take him out to an interview room. When I go door to door, I don't like to talk at great length about people's symptoms, people's delusional beliefs. I think appropriate place to do that, is an interview room, where they are not going to be overheard by the people who are constantly disruptive.

Q I just want to make sure that I understand what we [42] are talking about as far as your time. Unit rounds consist of you seeing, or reviewing, and making some form of personal contact, with all of your patients?

A On the lock units, yes.

Q Okay. How many patients, in total do you have on the lock units?

A I believe last week I had, I believe I had four. But, that number varies greatly from week to week.

Q Okay. From a high of?

A I've had as many as a dozen or fifteen patients, on the locked units.

Q And as little as?

A There have been times when I have had no patients on the lock units.

Q Okay. When you didn't have any, of course, you wouldn't need to make unit rounds there?

A That's correct.

Q Okay. So, during those times, when you make unit rounds, you say it takes a, – in total somewhere between five and thirty minutes?

A It been a long time since I've had as many as twelve patients on that unit. You asked for a range before, I think with that number of patients, it would probably be closer to forty-five minutes. We are talking about relatively brief contacts with everybody.

[43] Q I agree. Prior to the unit rounds, when was the last time that you had a interview session with Dr. Sell, besides the one that you've testified to, with Dr. Wolfson?

A I can't give you a specific date, it had been a period of a few weeks.

Q Where did that take place?

A I believe that the last interview I had with him, before the one with Dr. Wolfson, occurred on 10E, in the same interview room, one of the two interview rooms.

Q Do you maintain patient files?

A Yes, I do.

Q Did you bring your patient file on Dr. Sell with you here today?

A Yes, I did.

Q Okay. Would that assist you in being able to testify as to when and for what periods of time you interviewed Dr. Sell?

A I don't know that it would give me real specific information. After I see a patient, I generally put a note in

their chart, that talks about the content of the interaction, I don't always specify whether or not I took him out, to an unlocked, – to an interview room.

Q Well, you said you don't like to talk about their delusions, or other things, on locked wards out in the [44] hallway?

A That's correct.

Q Okay. Where is his chart?

A It is, – his chart is in my briefcase.

Q Could you get it for me, please?

THE COURT: You may do so.

(Pause Witness retrieving case file)

MR. LAWLESS: Could I see it?

(Pause)

BY MR. MARCUS:

Q Okay. There are a number of different categories in here. The notes on your interaction with the patient, would be under what?

A Under a ten, – it says, "Progress Notes," about third or fourth it's usually, it should be in reverse chronological order.

Q Let me ask you this, would the incident report concerning this conversation with the female nurse, that you've testified be in here?

A No, that's in a separate file, which I also have.

Q You have that here?

A Yes, I do.

Q Could you get that, please?

THE COURT: You may.

MR. LAWLESS: Thank you.

[45] (Pause)

BY MR. LAWLESS:

Q Okay. As I understand this, then, what he was placed into solitary confinement for was described as the following:

> "Inmate came to nurse's station for aspirin, he wanted to continue talking with this writer. When told, 'I didn't have time,' he stated, "You never have time for me, anymore, I'm not special anymore." He proceeded, to tell this writer, "You just don't realize, what you mean to me". Inmate was given a direct order to leave, that his behavior was out of line. He then stated, "I can't help myself". He has approached this writer in the past, and stated, "Hello, Michelle". He has been reprimanded before for this inappropriate behavior towards this writer."

Is that right?

A That was the, yes, – her description of the incident.

[46] Q Okay, you weren't there?

A No, I wasn't there.

Q Okay. And was there some discipline, – was there some hearing that he had with regard to this?

A No, there was not.

Q All right. If he was a convicted inmate, would he have had a right to a disciplinary hearing?

A Even as a pre-trial defendant, there is a disciplinary process. The clinician, in each case for patients, has the task of determining whether or not they are competent to participate in our internal, – you know, disciplinary process, –

Q Okay.

A – which is much less rigorous, than a corporal procedure, and I gave the opinion that Dr. Sell was not competent to participate in a meaningful manner, in our internal disciplinary process.

Q That he was not competent?

A That's correct.

(Pause – Attorney reviewing document)

BY MR. LAWLESS:

Q Okay, I'm sorry, I have a document here that's dated 7-20-99, –

MR. MARCUS: Can I see that, please, first?

MR. LAWLESS: Sure.

[47] (Pause)

BY MR. LAWLESS:

Q Let me hand you that to you and ask are you familiar with that from having, – your work with Dr. Sell?

A (Witness reviewing document.) I've not seen this before.

Q All right. Is that a document that bears the signature of the Warden?

A Actually, there's a signature of an Associate Warden, who I believe is acting for the Warden that date.

Q Okay. You recognize the signature?

A Yes, I do.

Q Okay. And in there the Warden states that, "As of the twentieth of July, Dr. Sell was competent to proceed in the disciplinary hearing," is that right?

A I'll have to take a moment to read it.

Q Please.

A (Witness reviewing document.) Okay, I've read it.

Q Okay. Does that indicate that as of that date, he was deemed competent to participate in a disciplinary matter?

A I don't think it indicates that.

Q What does it say?

[48] A This relates to a previous incident, –

Q I understand, I understand that, –

A Okay.

Q This was as of June 20th, of this year, – or July 20th, excuse me.

A Uh-huh (positive utterance).

Q Okay, and as of July 20th, the associate Warden or assistant Warden, whatever, was, – signed a document that said what?

A I believe this indicates that he was, –

Q Pardon me, would you, please just read what it says?

MR. MARCUS: Judge, I think he's argumentative, the questions aren't that clear what he's asking.

BY MR. LAWLESS:

Q What does that document say with regard to Dr. Sell's competency to participate in that disciplinary proceeding?

THE COURT: Okay. Let's all calm down, and just answer this question, okay.

THE WITNESS: Okay. "Additionally, a psychologist did not," – do you want me to read the whole thing or just the, –

BY MR. LAWLESS:

[49] Q Whatever relates to Dr. Sell's competency to participate, –

A

> "A psychologist evaluated that your condition, and determined that you are legally responsible for your behavior, and that you are competent to participate in disciplinary proceeding before the Unit Disciplinary Committee."

Q Okay. And that was as of what date?

A This response to his request for an administrative interview, was dated July 20th.

Q Okay. And the incident that you spoke of where he came up to the nurse's station and requested an aspirin, happened on July 24th, is that right?

A I believe that's correct. This incident would have occurred sometime prior to July 20th, I don't know the exact date, I believe it was at least two weeks probably more, previous to this document.

Q Okay. Let me hand you this.

(Pause)

BY MR. LAWLESS:

Q Does that cover that incident?

A Yes, this refers to that incident.

Q And it indicates that it occurred when?

[50] A June 25th.

Q All right. Do you know who would have made the assessment of Dr. Sell's competency as of June 25th?

A I would have.

Q Okay. So, on June 25th you thought he was competent to proceed in that disciplinary hearing?

A Yes, sir. Yes.

Q Okay. And on July 20th you thought he wasn't?

A That's correct.

Q Okay. And then when he's not competent to participate in that, what does he get, as far, as a hearing before he's put into lock down?

A When somebody is deemed not competent, and not responsible for an incident report, the incident report is basically expunged. As you see, a copy of it remains in their file. But there is no further action taken on it. When I made the decision, that I did not believe that he was competent to proceed, then the disciplinary report was no longer an issue and I wrote a clinical order to maintain him on the 10E living unit, on what we call behavioral observation status. So, even though initially he was moved back there as a result of the disciplinary report, after I made the assessment that he wasn't competent to proceed, it was my decision to have him remain on that unit, due to his clinical condition, [51] not for disciplinary reasons.

Q Okay. So you are the person responsible for his being there?

A Yes.

Q All right. Now, during, – Dr. Sell was initially sent to Springfield, back in 1997, is that right?

A That's correct.

Q Okay. And he was there for how long a period of time?

A It would have been a thirty day evaluation, he might have been a little bit longer than that. I don't know the exact dates that he arrived and departed.

Q All right. And during that period of time, did he present any behavioral problems that would have required him to have been put into any, –

A Not that I recall, no.

Q All right. And then he was again seen at Springfield, in the spring of this year?

A That's correct.

Q Okay. And, how long a period of time was that for?

A That was also for a thirty day evaluation, and he was probably there a total of forty days, I'm just estimating.

Q All right. He, –

A He had, – sorry, –

[52] Q That's okay. And during that period of time, was he permitted to remain in the general population?

A Well when the patients are first admitted, they generally are admitted to a locked unit. Then we evaluate them generally the day after they are admitted, because when they come in it is rather late, and as I recall Dr. Sell was on an unlocked unit the day after he arrived.

Q All right. And then when he was sent back for determination as to whether or not he could be restored to competency, when was that?

A He arrived at our facility for the competency restoration commitment on April 20th.

Q April 20th, and he was then sent to lock down in July?

A July 24th.

Q And, during that period of time from April to July 24th, he lived on the open ward?

A That's correct.

Q Okay. Had he been involved in any assaultive behavior?

A No.

Q Had he made any threats, that you are aware of?

A No direct threats.

Q Now, as his treating clinician, have you been [53] involved in any therapy with him since his return to Springfield, in April of this year?

A He was involved in a competency restoration where we use psychological education group that focuses on issues relating to competency, –

Q But was that to educate people on who the judge is and what the lawyer is?

A That's a large part of it.

Q He knew those things, didn't he, he knew, –

A Yes, he did. We'd also focus on such issues such as how effectively help your attorney, how to behave in the courtroom.

Q None of those were issues with him, were they?

A It was my understanding that his behavior in the courtroom was an issue.

Q How's that?

A I understand that he has had a disruptive behavior in the courtroom in the past.

Q What did that consist of?

A I understand that he has spit at a judge.

Q And did that take place in a courtroom?

A I believe it took place in a holding cell.

THE COURT: It took place in a proceeding, Mr. Lawless in all fairness.

MR. LAWLESS: I understand that, Judge.

[54] THE COURT: An initial proceeding.

BY MR. LAWLESS:

Q Do you know whether Dr. Sell was represented by an attorney at that point?

A I don't know the details of the event.

Q Do you know whether or not his attorney was present during that judicial proceeding in the Marshal's lock up?

A I don't recall. I don't know if I've ever known that.

Q Other than the competency restoration group, have you been involved in, or provided anything else in the way of therapy for Dr. Sell since he was returned to Springfield for competency restoration?

A No, I haven't.

Q And when did that competency restoration group conclude?

A The group, met, – it meets on an ongoing basis, on a weekly basis. Dr. Sell was removed from the group, due to his disruptive behaviors within the group.

Q And that consisted of?

A He insisted on discussing his case to the exclusion of the information that was applicable to everybody. And it was my understanding from the group leaders, that he did so in a very controlling and disruptive fashion [55] and he would not respond to directions to refrain from doing so.

Q Now, the nurse that he was supposed to have made these inappropriate comments to, her name is what, Goldberg?

A That's correct.

Q Okay. And Nurse Goldberg was the individual who was originally selected by Dr. Sell, to be his staff representative at his institutional involuntary medication hearing, is that right?

A That is correct.

Q And from reviewing Dr. Sell's file, the reason that he had picked Nurse Goldberg was because he felt she was someone he could get along with and trust?

A I believe that's right.

Q And she then declined to represent him, at that institutional hearing, is that correct? Claimed, – stating that there were some scheduling changes which made it impossible for her to serve in that capacity?

A That's correct.

Q And that institutional hearing took place when?

A June 9th of this year.

Q All right. Now, on l0E is Dr. Sell allowed to have his eyeglasses?

A I don't really know if he is, I don't believe he is [56] allowed to have eyeglasses. I think the regulations prohibit having glasses with metal frames on that unit.

Q Okay. Would he be permitted glasses with plastic frames in that case?

A I believe so.

Q Okay. Does the institution provide him with those so that so that he can see?

A I don't believe that we have.

Q All right. He is fed in his cell?

A That's correct.

Q Okay. They stick a tray in through a slot in the door?

A That's correct.

Q Solid steel door?

A Yes.

Q Okay. Does he have any control over when the lights are on in the cell?

A He can control that to the extent that he asks staff members to turn them on and off.

Q And if they comply with this request then they're turned, – are they on or off for everybody or just for him?

A That could be, the cells are all set up the same way. I'm not sure I understand the question.

Q Okay, if one to turn off the lights in his cell [57] would it turn off the lights in all the adjoining cells or just his cell?

A Just his.

Q Okay. But he has no physical control over when the lights are on or off in his cell?

A That's correct.

Q And I think you already answered, Mr. Short, that his access to legal materials depends upon staff there?

A That's correct.

Q Okay. Is he permitted any books?

A Yes.

Q How many?

A I don't know what the limit is, I believe it's two or three paperback books, which he can swap out on a daily basis.

Q Okay. And then he's permitted a pencil to write with, that they bring around once a day?

A That's correct.

MR. MARCUS: Judge, I'm going to object for a couple of reasons. Number one, it's been asked and answered; number two, I think we're getting outside the scope of the purpose of the hearing today.

THE COURT: Yes, Mr. Lawless maybe we are as to the conditions, although you have your reasons for painting the conditions, and –

[58] MR. LAWLESS: Well Judge, I think, –

THE COURT: I think we have an idea, –

MR. LAWLESS: I think it's more than that. I think that the knowledge with regard to the delusional disorder, the fund of knowledge that's out there in recognized texts, suggest that isolation is contraindicated and that, in fact, what looks to be the most pre-textural of reasons, Dr. Sell has been placed in this isolation as a punitive measure to exacerbate his symptoms, in order to justify his medication.

THE COURT: Okay. Then why don't we get to it, if that's what you are contending.

MR. LAWLESS: All right. All I can do is lay the ground work for it and ask the Court to consider whether that's a correct conclusion or not.

THE COURT: All right. Fine.

MR. LAWLESS: Thank you.

BY MR. LAWLESS:

Q As I understand your testimony, then the only treatment that you feel is appropriate for delusional disorder is medication?

A It's the only treatment that is, – that the literature has shown to be consistently effective.

Q What literature is that?

A A fairly broad base of psychiatric/psychological [59] recent articles.

Q What are those articles? If you have them with you.

A I cannot name, – I don't have the articles with me, and I can't name them, I know I've reviewed several.

Q Okay. Well, let me ask you this, what, – are these matters, with regard to medication, fall more into the realm of psychiatry or psychiatry?

A Psychiatry.

Q All right. In what text would you consider to be authorative, in the area of psychology?

A I believe there is the, *Comprehensive Review of Psychiatry* and we have the name of the book, the authors are Kaplen, K-A-P-L-E-N and Sadock, S-A-D-O-C-K. That's the only psychiatric text that I use regularly. I know our consultant psychiatrist, Dr. Wolfson, has a large volume of psychiatric text that he relies on.

Q Okay. And Kaplen and Sadock, what do they say with regard to the treatment of delusional disorder?

A My recollection is that they say, anti-psychotic medication is the treatment of choice.

Q Any other text that you would recognize as authorative?

A There are other authorative text, I can't name them, I would probably recognize them, that states that [60] I have borrowed them up there.

Q You are familiar with the Affidavit of Dr. Cloninger that was filed on this case, and the studies that were cited in his Affidavit?

A Yes, I am.

Q Okay. And he is a psychiatrist, is he not?

A That's correct.

THE COURT: I am going to take notice of that Affidavit for the purposes of the record, –

MR. LAWLESS: I appreciate that.

THE COURT: – here, Mr. Lawless and –

MR. LAWLESS: I think the original actually was filed, – with, at the hearing in Springfield, I left it there with the hearing officer.

THE COURT: It well could be. You've provided me with a copy plus there's a copy in the file.

MR. LAWLESS: Thank you.

BY MR. LAWLESS:

Q And Dr. Cloninger, in the articles that he cites indicates that treatment by psychotropic medication is contraindicated, is that right?

A In the two sources he cited, I believe he agreed the conclusion that treatment was generally not effective.

Q Drug treatment?

[61] A That's correct.

Q And the *Merc Manual*, you're familiar with that?

A Yes, I am.

Q Volume, I think they are now in sixteenth publication of that. Does that indicate that drug treatment is contraindicated for delusional disorder?

A I don't know what the manual says about delusional disorder.

Q Okay. Do you rely on it?

A No.

Q Never?

A Not in my practice, no.

(Pause)

MR. LAWLESS: Judge, what I have handed the Government, the Witness and the Court, is a report from the Federal Bureau of Prisons Institution Metropolitan Correctional Center, concerning a former client of our office who had executed a release. I don't think that it serves any purposes to bring the patients name up –

THE COURT: No.

MR. LAWLESS: – in this proceeding, and I don't intend to. But, I would suggest that this individual was diagnosed with delusion disorder. And then I would draw the witness' attention to pages 7 and 8 of that, – under the second sentence of "Prognosis [62] here,

> "The opinion of this examiner was that the patient adhered to a system of beliefs which may be termed delusional; individuals who suffer from a delusional disorder often do not respond to mental health intervention."

On page 8, last paragraph that begins at the bottom of the page as noted in the "Prognosis" section;

> "Delusional disorder does not typically respond to pharmacological intervention or psychotherapy".

And I would ask this witness if he is familiar with Daniel Greenstein, the forensic study psychologist, at the MCC in Chicago?

THE WITNESS: Yes, I am familiar with him.

BY MR. LAWLESS:

Q Okay. And Dr. Greenstein's statement, with regard to recognized efficiency of psychotropic medication, is then incorrect?

A I believe that's incorrect.

Q And the date of this report was July 1st of this year?

A Yes.

[63] Q So you disagree?

A Yes, I disagree with this. I didn't disagree with the statement, that delusional disorder is not typically responsive to psychotherapy, obviously I don't know anything about the case.

Q Okay. The two cases that you have referred to, you say one was treated with Haldol, is that correct?

A Yes.

Q In your opinion, that person was restored to competency?

A That's correct.

Q And, what aspects of their mental illness did you, – was it, in your opinion was the Haldol effective in treating?

A This patient had a complex delusional system, of several different things. After his treatment with anti-psychotic medication, he no longer endorsed those delusional beliefs, and, in fact, he appeared deeply embarrassed when they were discussed, – he was embarrassed that he had ever held these beliefs.

Q Did this patient suffer from hallucinations?

A No, I, –

Q Prior to the treatment with medicine?

A I don't believe so, it's difficult to recall all the specifics of the case. I don't believe that he [64] reported any hallucinations or that we saw any evidence of hallucinations, prior to the time that he was diagnosed as a delusional disorder.

Q And, so your opinion, – your testimony then is that, delusions respond to medication?

A Yes, in many cases they do.

Q Now, Dr. Sell has been previously treated with Haldol, unsuccessfully is that true?

A I don't think that's necessarily true.

Q He was treated with Haldol?

A Yes

Q Okay. And that would have been back in the '80(s)?

A That's correct.

Q Okay. And in your opinion, has he been suffering from delusional disorder now for some sixteen, seventeen years? Based on his history?

A It's clear that he's had a psychotic illness that dates back at least that far. I don't know what the course has been, whether or not the symptoms have been continuous or sporadic. I don't really feel comfortable saying he's had the illness in the current form for any period of time that goes back farther than when I met him.

Q But his history was part of what you relied on in making the diagnosis?

[65] A Yes, he clearly had a history of psychotic symptoms, and had been diagnosed with psychotic disorders in the past.

Q All right. And I believe your testimony on direct examination was that, delayed treatment from the onset of the illness, was a factor that would indicate that medications, – treatment by medications would be unsuccessful?

A What I said was, that a delay of treatment from the onset of the illness, is likely, in some cases, to delay the time until a response, and it may diminish the effectiveness of the response. I will not say, just out right that the treatment wouldn't be successful. But, I do think you run risks of the patient not getting better, as quickly or not getting a recovery that is as complete.

Q The patient that you, – that was treated with Haldol, how long from the onset of their mental illness was it till you began their treatment?

A I don't recall specifically.

Q Seventeen years?

A I don't know.

Q Do you know what the patient's age was?

A Late fifties.

Q Late fifties?

[66] A Yes sir.

Q And the other patient that you treated, with Olanzapine?

A Olanzapine.

Q – pine.

A Actually, I did, – was not the treating clinician. I participated in a risk assessment, assessment of dangerousness of this individual.

Q Did they suffer from hallucinations as well delusions?

A No. He suffered exclusively from delusions.

Q And they were not restored to competency?

A That's correct.

Q How long were they treated with this medication?

A I believe they were treated with medication for approximately eight months, during which time there was significant improvement in the clinical condition, even though they weren't restored to competency.

Q The person that was treated with Haldol, how long were they treated?

A I believe about five months.

Q Now, is or is not psychotherapy one of the recommended treatments for delusional disorder?

A I do not believe that's generally recommended for delusional disorder. It will not help a delusional [67] patient out of his delusions. It a feature of the illness, the beliefs are going to be held very firmly, and efforts to dissuade somebody from those beliefs generally results in the person providing treatment being incorporated into the delusional system.

Q Well, I certainly wasn't trying to limit psychotherapy to trying to talk someone out of their delusions. Forgive me if you misunderstood. Can't an individual who suffers from delusional disorder be worked with in order to minimize the adverse affects of their delusions?

A There can be a lot of different focuses of therapy and I apologize for being sloppy in saying, talking him out of a delusion, that's probably not very precise. I think sometimes it might be an appropriate focus of treatment to work with the person on how their beliefs are affecting their ability to function. Typically, that is not successful.

Q That has not been tried in Dr. Sell's case?

A Not on a sustained basis and what you would consider or what anybody would consider a traditional course of psychotherapy.

Q Okay. I think your testimony was the only psychotherapy was this competency restoration group?

A That's right, I had more of a psycho-educational [68] focus which did not, – in the group they did not, – they did not, focus on people's individual cases, their charges, their false beliefs, it's move psycho-educational.

Q At the present time, there is no plan on your part to release Dr. Sell from 10E?

A I have no specific time line, my, – I hope to release him as soon as his condition permits, it's much easier to work with somebody when they are not in such a restrictive environment.

Q And as I understand, Dr. Sell makes some statements that you feel are inappropriate and you send him to 10E?

A I think that kind of misses the reason that he went to 10E. It wasn't necessarily for the inappropriate statements he made, it was due to concerns about changes in his thought process, that would put him at risk to others. I believe the comments reflected significant deterioration in his clinical state.

Q Would it be unreasonable for someone in Dr. Sell's position to view his being put into 10E as punishment for the statements he made to the nurse?

A No, it's not unusual.

Q Nor unreasonable under the circumstances, is it?

A I don't think it's accurate, but it is probably reasonable from his perspective.

[69] Q Did you discuss With him the reasons for his being placed on 10E?

A Yes, I did.

Q What did you tell him?

A I told him that staff had increased concerns about his safety, about safety of staff around him, I expressed to him my beliefs that his condition continued to deteriorate, and would probably worsen over time without treatments. And, I told him that I wasn't going to try to talk him into taking anti-psychotic medications, even though he was free to say, "I'd like to start that," but of course, I was aware that this proceeding was pending, and, – you know, for that reason I didn't try to apply, I didn't try to persuade him as much as I might other individuals who need the medication. There's a process, a legal process involved here that I didn't want to disrupt or try to get out of.

Q Was there any attempt on your part to suggest that there might be a gradual restoration of institutional rights, based on behavior on his part?

A Yes, I have talked of that.

Q Okay. And, he's been locked down now, this is the end of September, lock down took place the end of July, so – we've got August, –

A A little over two months.

[70] Q Two months. Has there been any assaultive behavior on his part during those two months?

A No, there hasn't.

Q Okay. Has there been any inappropriate comments that he's made towards staff during those two months?

A Yes, there has.

Q And what were those?

A After the incident with the nurse, he was discussing that incident with a correctional officer, who noted in the medical record, that Dr. Sell said that he loved that nurse, and that is also when he made the statement to the effect that, he has not touched her but he would if, –

Q Okay, that was shortly after the incident, as I understand it, –

A I believe it was about a week or so, after the incident.

Q Has there been, – that was him discussing, – within 10E itself, has there been anything about his behavior that's been inappropriate?

A I don't recall any behaviors that have been inappropriate since he has been on 10E.

Q So, what does he have to do, to get out of there?

MR. MARCUS: Judge, I am going to object that this is not a function of this hearing, getting him in [71] or out of 10E, this is a decision they made for their own safety.

THE COURT: Okay. Mr. Lawless at this point, I am tempted to sustain the objection, only because the record is efficiently made, if you have something else you need to do, you may do it at, I must ask you –

MR. LAWLESS: I have a real question about this additional claim of dangerousness, as it impacts on

the justification under the cases for the involuntary administration of medication.

THE COURT: You may explore that, although you pretty well gotten into it, if you have something else you want to do about it, I just ask you to do it, okay.

BY MR. LAWLESS:

Q Has Dr. Sell been the subject of any assaults while he's been on 10E?

A No, not that I'm aware of.

Q Okay. He hasn't assaulted anybody?

A No. Due to the nature of the unit, he would not have an opportunity to assault anybody.

Q Are you telling me there haven't been any assaults on prisoners in 10E since he's been there?

A I wasn't finished with my statement yet. There would be no opportunity for him to assault anybody in an effective way. Basically, the prisoners are let out of [72] their cells in handcuffs, with staff present and, – but the very nature of the restrictive unit goes a long way to prevent assaults. I'm not saying that no assaults have ever occurred on that unit.

Q Have there been assaults since he's been there?

A I'm not aware of any assaults on staff since he's been there, I do believe there have been assaults between patients when they've been out on the recreation yard.

Q All right. So with out a recreation yard he can be out there with other individuals?

A Yes.

Q Okay. And he hasn't been involved in any assaults against any other individuals out there?

A Not that I'm aware of, no.

Q Are you aware of his ever been convicted for any assaultive behavior?

A I'm not aware of any such convictions.

MR. LAWLESS: All right. Can I have a moment?

THE COURT: Sure. Certainly.

(Pause)

MR. LAWLESS: I don't have anything else at this time, your Honor.

THE COURT: Mr. Lawless, I didn't agree, – [73] obviously I'm, –

MR. LAWLESS: I didn't feel that way. like that.

THE COURT: – you had something to do, you do it, okay.

MR. LAWLESS: Thank you.

THE COURT: Mr. Marcus.

MR. MARCUS: I have no redirect.

THE COURT: Dr. DeMier, thank you very much. You may be excused.

WITNESS: You're welcome, your Honor.

THE COURT: You may call your next witness. I'll take that back, why don't we take about three, – five minute recess.

(Temporary Recess From 10:50 p.m. Until 11:05 p.m.)

THE COURT: Mr. Marcus, you may proceed.

MR. MARCUS: Your Honor, at this time the Government would call Dr. James K. Wolfson.

JAMES K. WOLFSON, GOVERNMENT'S WITNESS, SWORN

DIRECT EXAMINATION

BY MR. MARCUS:

Q Sir, for the record can you state your name please?

A Yes. James K. Wolfson, M.D.

Q And Mr. Wolfson, where do you currently work?

A I'm at the U.S. Medical Center for Federal [74] Prisoners in Springfield, Missouri.

Q And what is your current position there?

A I'm a staff psychiatrist, I'm the only psychiatrist who is on the forensic service along with other psychologists colleges.

Q All right. Dr. Wolfson, I'm going to hand what has been marked Government's Exhibit 3, and ask you to identify this for us please?

A This is my Curriculum Vitae.

MR. MARCUS: Your Honor, at this time I'd offer Government's Exhibit 3 into evidence.

MR. SHORT: I have no objection.

THE COURT: It be so admitted. Thank you Mr. Marcus.

Q All right. Dr. Wolfson, as staff psychologist at the Medical Center in Springfield, had you been involved in the treatment of Dr. Sell?

A Yes, I have.

Q And, would it be fair to characterize your role in his treatment as a consultant?

A Yes, it would be.

Q And, one of the issues you are involved in consulting, would be the potential use of medication for him?

A Yes. That is how I'm connected to everyone of the [75] competence restoration cases we receive, committed under 18 USC 41:42(D), either and attending or as a consultant.

Q And, in your capacity as a consultant, were you, – you've had an opportunity to have various interactions with him?

A I have.

Q And, how would you characterize the nature as your interaction with Dr. Sell?

A Well, I have been present on a more limited number of times than has his attending clinician, Dr. DeMier. I was present for initial interview, on his return to our facility, present on a handful of other occasions, saw him just a two days ago now, and was also present at his due process hearing. Probably, something under six hours

of total contact time in terms of intensive interview time. And then during the times that he was out among the population in the prison area, I would encounter him on a casual basis, multiple times a week.

Q All right. Dr. Wolfson, based upon your contacts with him, your review of the records and the diagnosis provided by Dr. Demier, in your opinion would you consider Dr. Sell to be psychotic?

A Yes.

Q And based on your experience, what is the [76] appropriate treatment for psychotics?

A Anti-psychotic medication is the appropriate treatment to relieve psychotic symptoms.

Q Now, Dr. DeMier diagnosed Dr. Sell as suffering. from delusional disorder, you are familiar with that diagnosis?

A Yes, yes I am.

Q And, the diagnosis of delusional disorder, that is a relatively recent label, – or diagnosis?

A It's a recent premeditation of an older concept.

Q In 1987, that was added as the label, delusional disorder?

A Correct.

Q Now, in your experience and your training, have you seen people that have come in with particular diagnosis and end up with another?

A Yes, I have.

Q And, in Dr. Sell's case, what is his opinion on his diagnosis?

A I am deferring, a definitive opinion on his diagnosis, it's clearly psychotic. The diagnosis of delusional disorder is a plausible one, there are some potential features to his history, plus, a level of caution I prefer to adopt overall, that leads me in a situation where I am not comfortable, excluding the [77] notion of schizophrenia, as an alternate explanation to his symptoms.

Q And, whether it's schizophrenia, or delusional disorder, these are merely labels that have been applied to a set of symptoms?

A Yes. They're labels, they should have utility when they are applied correctly and cautiously, but they are labels.

Q And, based your experience and your training would it be fair to say that both schizophrenia and delusional disorder can respond to anti-psychotic medication?

A Certainly, and that one of the reasons why there doesn't need to be a rush to diagnosis, prior to selecting appropriate therapy.

Q And, it wouldn't be unusual in terms of behavior to see a continue, where a diagnosis might change or a label may change?

A Diagnosis change primarily as more information about a patient accumulates, as more time and contact and more longitudinal course occurs. Every now and again, the diagnostics team also gets changed around, so that we have to revise what labels, most usefully, to characterize that patient's problems.

Q But, in Dr. Sell's case no matter what the labels applied, you still believe that he is psychotic?

[78] A Yes, that's, – that part is unequivocal.

Q Now, you indicated that you believe the appropriate course of conduct to treat someone who would be psychotic, whether they were schizophrenic or suffer from delusional disorder, would be the anti-psychotic medication. And, what is your opinion as to what will happen to Dr. Sell, if he is not treated?

A I anticipate that he will deteriorate. He's likely with the one diagnosis of schizophrenia, more likely with the other diagnosis of delusional disorder, which is less likely, to reach a spontaneous remission. I anticipate that he will have further loss of function, his liberties have already been severely curtailed, if we do not address his illness, that's likely to get worse.

Q And, would you believe, – view this, deterioration of conduct as something that will be ongoing and continue unless treated?

A Yes, I do.

Q And any response that the medical center has instituted, in terms of how they house him would be in response to his deteriorating condition?

A That has been, – yes, that's been related to his current circumstances.

Q Now, since June of 1999, have you seen specific [79] changes in his conduct?

A I've seen some and heard about more.

Q Okay, so your opinion would be based on you've seen and what you've heard, in review of your records?

A Correct.

Q And, are you familiar with his conduct becoming more directed and personal?

A Yes.

Q And, what does that mean?

A Well, one of the concerns, and what played a role in him leaving general population status, and moving to locked unit, had to do with apparently developing a relationship or connection to one of the nurses. That left us with significant concern.

Q And, what were your significant concerns?

A Well, he was, speaking as if he was attached to her, I don't remember the precise phraseology, but something, – that he'd been overly friendly with, – he'd been discouraged as any prisoner would be, had not responded to being discouraged from her, and after an episode where he was finally brought out of general population, I believe he made a remark to one of the correctional officers, "I didn't touch her, I would have if she'd asked me," I don't remember the rest of it verbatim.

[80] Q Did he indicate that he was in love with this nurse, and could not help his behavior?

A He did, which is somewhat of an uncertainty for someone in that position, that's indicative of his degree of impairment.

Q Okay. Would it also be indicative of his cognitive slippage, and his inability to function, or know reality?

A I think so. I mean it certainly stands as a start contrast, to his career and most of his life history. I don't think, a person, a responsible physician, now in this position doing these things, at a place like this.

Q When he was initially confronted with his behavior, did he discontinue it immediately?

A No.

Q Now, in your experience, when other prisoners have made inappropriate comments and they have been noted, what is the response?

A Typically, they comply, particularly if they can understand the adverse consequences on their housing situation. We occasionally meet some people who are stubborn and take longer to do that. But, the idea of an intelligent man, being unable or unwilling to see the writing on the wall, continuing until something like this happens, that's a sign of deterioration.

[81] Q Now, in light of his history, either mental health history or history of conduct, and the new conduct concerning the nurse, did it raise any type of heightened worriedness (sic) or concerns on your behalf?

A It did, and I have less in the way of specific information that I would like to have in this particular setting about his prior contact, but it was my impression that there had been problems with a tendency to get fixated on a particular topics, to be tenaciously embroiled in them, other than correspondence to members of the Dental Board, issues with office employees, again I don't

have as many facts as I might liked to have to outline this. But, it seems to be a recurrent theme, it's a recurrent problem rather than an anomalous, one time transit issue, that's my impression.

Q And based on this did you note there to be any immediate risk?

A Immediate risk is tough to qualify, but if they have a fellow who isn't or won't modify his behavior, that's talking about being in love with one of the nursing staff, yes, we can't leave that person out in a position where they can get themselves into further trouble or cause difficulty, for staff members or –

Q Did Dr. Wolfson, did the nurse consider this a threat or danger to her?

[82] A My understanding is that she did.

Q And, does this raise issues of erotomania or delusions of erotomania?

A Well, yes, and that's particularly significant since that, it's thought it was independent subtype, but that is a phenomena seen in delusional disorder, that would be consistent that diagnosis, and if that is indeed what was happening, then it could presented as a very severe problem and very difficult to do anything about once it gets entrenched, if action isn't taken early.

Q When you say difficult, difficult for who?

A Difficult to modify what Dr. Sell would be thinking and difficult to modify what he would do.

Q Given his history and given this conduct that occurred in the light of the psychiatric history and the

information that you have, do you perceive Dr. Sell, in your opinion to be dangerous?

A Broadly defined, yes.

Q And, he sits now, he is in a very restrictive, – the most restrictive set of circumstances?

A Just about, yes.

Q And, that is a result of this perceived danger?

A Correct.

Q Okay. Now based on your expert opinion, and your [83] experience, and your training, what do you think the affects or what is your opinion as to the effects of anti-psychotic medication concerning Dr. Sell's dangerousness?

A I anticipate that it will alleviate it, or reduce it to make it more commandable (sic) to additional interventions such as psychotherapy or behavioral interventions.

Q So, you feel it would be necessary to go through medication first and psychotherapy later?

A I think the medication is a foundation, to whatever form of therapy happens after that. Without it, one cannot anticipate success or meaningful benefit from other therapy interventions. So it may not be sufficient, but is necessary.

Q Now, let me ask you about your prior use of anti-psychotic medication. In the past have you used anti-psychotic medication to treat psychotic patients?

A Yes, I have.

Q And, approximately how many patients have you been involved in the treatment of with anti-psychotic medication?

A Hundreds, my best guess, I really don't recall, somewhere between one and two-thousand.

Q And, in the one and two-thousand you've treated [84] with anti-psychotic medication, have you seen positive results?

A Oh, yes.

Q And, would it be predominantly, in most cases there is an improvement?

A Yes. That's both the conventional wisdom and the research literature, and it's been my own experience.

Q And, as a psychiatrist you are aware that there are some potential unpleasant side effects of the anti-psychotic medication?

A Yes, there are for most medications that are used in any medical specialty and that's true with this.

Q Can you identify any of the unpleasant side effects, that I'm going to categorize those as one set as opposed to a dangerous side effects?

A The most predominant, or conspicuous problem which lies with what are called the high potency conventional anti-psychotic medications, relate to changes in movement and motor function. It can involve a peculiar type of stiffness which may relate to general body posture or may involve spasm of particular muscles in the body, which some has been treatable. And may also involve

peculiar type of restless sensation, sometimes a sensation of slow movement overall, analogous of it to have seen in Parkinson's disease. For that reason, [85] symptoms are subject Pseudo-Parkinsonism.

Q And, are these effects treatable in the institution?

A Oh, yes.

Q Are there any other unpleasant side effects that you have encountered, or read about?

A Well, some individuals will find the medications sedating, there's a continuum of degree of sedation, with different agents. Obviously, our goal is to get patients back so they can defend their cases, and having them sleeping in the courtroom is not the desirable goal, so I tend to chose medications that do that less.

Q Would it be fair to say that, most of the unpleasant side effects can be dealt with by the institution, by either other medical treatments or other medicines?

A Sure. Occasionally there is patient who will have to chose which is worse, some anxious of illness or the side effects, and that's an analysis that almost always favors treatment. There are occasional patients that can tolerate symptoms so that there is a choice that he can actually make about it. But, for the majority of patients, there really is only one sensible choice. But, most patients don't have to expect problematic side effects as the cost of having their illness treated and [86] having control of their own thoughts and minds.

Q Now, in addition to unpleasant side effects, there are also some serious side effects, would that be correct?

A That is correct.

Q And wouldn't it be neuroleptic malignant syndrome?

A Indeed.

Q And, between the thousand and two thousand patients, which you have personally treated with anti-psychotics, have you ever seen this occurring?

A I've seen it, but not in my own patients. None of the patients I have treated are prescribed this type of medication and have developed this.

Q And, in the course of your experience as a psychiatrist, in a, – you have been involved in many large mental health facilities?

A Yes, I have.

Q Many occasions in which, perhaps you weren't involved in the administration of anti-psychotics, but other doctors have?

A Yes.

Q And this would be into the thousands?

A I'm sure.

Q And, how many times have you seen occasions of neuroleptic malignant syndrome?

[87] A During the time I was at Barnes, and Malcolm Bliss and Jewish, and Children's, and The University of Washington in Seattle, Harvard and the University hospital there, U. & M., and then my current employment, I have known of two cases of neuroleptic malignant syndrome

being present in any of those hospitals, at the time, – it's the kind of thing that news spreads from the staff because it is important, it's also interesting. And it's roughly consistent with the, – estimates vary as to it's actual frequency, but a reasonable guess as to it's incidents is something like one in ten thousand cases.

Q Now, based on your opinion, and a cost benefit analysis, and other pertinent, – not a cost benefit analysis, but in terms of risk analysis, do you feel the risk of the continuing illness is greater than they risk of him receiving this medicine and developing this type of scenario?

A No. No question about it. That's why the more typical cases, treating patients voluntarily rather than having to take the decision making process out of their hands like we are doing here.

Q Now, as the consulting psychologist, you would be involved in the actual medication, deciding what's appropriate, and what would be best for him?

[88] A That's correct.

Q And, just in general from a lot of the literature concerning treating the delusional disorder, there's a, – Pimozide is considered a very workable medication?

A It's in the literature, yes.

MR. SHORT: I didn't hear what you said, I didn't hear the drug?

MR. MARCUS: Pimozide, P-I-M-O-S-I-D-E.

MR. SHORT: Thank you.

BY MR. MARCUS:

Q That's been noted in, various studies in the papers?

A That notion is in literature, yes.

Q And, – but in your experience you would prefer more of an atypical, anti-psychotic?

A I'm not certain of that, it was last reported severe characteristics compared to the conventional anti-psychotic medications rarely would be borne out. And there's no theoretical basis for expecting it to be better. The newer drugs have substantial advantages, that I think would probably outweigh any special nature that Pimozide might have, compared to the other older drugs.

Q Pimozide is just been, – it's been discussed quite a bit though, in literature?

[89] A Yes, it has. For this and a couple of other unusual conditions, perhaps somehow being different, but not different to the extent that you are referring to.

Q Sure. But as we noted, atypical anti-psychotics might be appropriate?

A In general, they are preferred in most situations. They generally have a more benign side effect profile, and they also have improved effectiveness for aging patients who failed to respond to conventional treatment, which is not an issue here. There hasn't been much conventional treatment, I've seen perhaps two patients who did better on the old drugs than on the newer drugs, but by and large they are preferred.

Q But based upon your training and experience, your expert opinion would be that the atypical anti-psychotics would be more appropriate for Dr. Sell because, they have minimized side effects and they have increased chances of working in terms of his condition?

A Yes, I believe so. I should mention that one potential limitation and that they are available only in oral forms, so I need a cooperative patient taking them. But, if I have that uncooperative patient and I am confident that he is taking medication, not faking his pills out or something like that, I believe they are preferred.

[90] Q Now, let me ask you this, what medications would you propose for Dr. Sell if you were to treat him?

A I prefer not to get pinned down to a single drug, because part of this I hope to actually leave in his hands, to pick among available alternatives, so he can at least have some role in the decision making process. Of the atypical agents, there are two; Quetiapine, – should I spell that for the transcription, – Q-U-E-T-I-A-P-I-N-E, –

MR. SHORT: I'm sorry, can you spell that again please?

THE WITNESS: Quetiapine. Q-U-E-T-I-A-P-I-N-E, sold as the brand name Seroquel, S-E-R-O-Q-U-E-L. And, another medication, Olanzapine, O-L-A-N-Z-A-P-I-N-E, which is sold as Zyprexa, Z-Y-P-R-E-X-A, and those are the, – I think the two of the three, for atypical agents, those are the two that make the most sense. There is another one that they are hoping to have in a few months, that on paper looks very promising as well called Ziprazodone, Z-I-P-R-A-Z-O-D-O-N-E. As usual, there's experiment in Europe well before it's introduction here. So that

can be considered to, if shows up in time, but those are the ones that make the most sense, be most likely to have a benign side effect so profile.

[91] BY MR. MARCUS:

Q All right, Dr. Wolfson, is your expert opinion that this medication would render him less violent or less dangerous?

A I think by addressing his illness, it should also seek to reduce whatever portion of dangerousness might be related directly to the illness, and by improving his cognitive abilities overall, might even be helpful for dangerousness or orneriness, if there is any from any other source.

Q And, you believe these atypical drug, are best suited for him?

A I believe so.

Q Okay. Dr. Wolfson, are you familiar, at least from the records, from Dr. Sells prior use of Haldol?

A I am.

Q And, that would have been in the '80(s)?

A 1984, is the year, I'm thinking, but that's incorrect, it's 1982.

Q And, how successful was the Haldol, from the records in terms of Dr. Sell's usage of it?

A Well, he was able to be discharged from the hospital, what happened after that I guess is a matter of conjecture, but it would certainly appear that it worked

acutely, to the extent one could tell from the [92] records more than a decade later.

Q So, in other words he took the Haldol, allowed him to get gate passes, get discharged, go back to work?

A Yes.

Q And, do the records indicate he was able to tolerate Haldol?

A The records mention a, – one dystonic, reaction, that's the type of muscle spasm I mentioned, it was coped with by a reduction in medication dose, and I do not recall seeing any other mention of problems tolerating the medication. Now, Mr. Sell, I'm sorry, Dr. Sell has told me that he had all types of problems with it, I don't know if that's a post talk contrite statement on his part, but if he had been and if it happened during the hospital, I anticipate that would have been mentioned here, – been mentioned in the record. It would led to further modification in his regimen.

Q Okay. Now, can you tell me how many patients have you treated that have been diagnosed with the delusional disorder?

A I have treated three patients outside of a legal setting, and I have treated four patients, one of them on two separate episodes, – two separate competence restoration commitments. So, four patients, five times [93] in my current setting,

Q And, of the group of three, and the second group of four, how many did you treat with anti-psychotic medication?

A All of them.

Q And, what was, – what were the results with the use of the anti-psychotic medication?

A All benefited clinically. Naturally, the three long term clinic patients I had during residency were not involved in legal entanglements at that point, so there wasn't the additional issue of competence to proceed with a legal case. But, all three of those patients did well, didn't need to be hospitalized, rather returned to their homes, – one returned to employment, the other two hadn't been employed already for many years. Of the four that had, the four patients that had come through the medical center, – I believe there are probably more – but there were only four whose names I could chase down with the limited time I had. Of those two cases, that were defendants were assigned to my own caseload, I was their attending and wrote the report. One of those was the fellow who has come back a second time, I restored him successfully to competency once, and have just about succeeded the second time. The other case that was mine that did not [94] successfully restore to competence, he nonetheless benefited substantially, clinically, and I went by, – he is back at our facility on another practitioners caseload, and I stopped by to see him on Monday, and he has improved enough that his release from custody if currently being planned. There are two other patients, was probably like another, who were attended to by different practitioners whom I treated, both of them were restored to competence to proceed. So, small numbers, but I guess from that we calculated 80% success rate for successful restorations on a five treatment facility.

Q Okay. Dr. Wolfson, based on your experience and your expert opinion be that you feel that you have a good chance at restoring Dr. Sell, if you are given the opportunity to medicate him?

A I believe I do.

Q Do you believe that it would be appropriate medicine to withhold anti-psychotics from a psychotic?

A No, that's not appropriate. In a sense that betrays what we're all about.

Q Now, the Physicians Desk Reference lists a series of medications ranging from Tylenol to anti-psychotic medications, and in there, there are some detailed lists of potential side effects and consequences, are you [95] aware of the *PDR*?

A Yes.

Q And what is your opinion, in terms of the *PDR* in terms of being a valid treatise, – or a valid source of information for a psychiatrist?

A Well, it depends on what contents it is being used in as an authority. The *PDR* is a convenient compendium of legal information produced by the drug companies that produce and pedal the medications. In as such it may have flaws, that relate to their commercial interests, and certainly has flaws that relate to their liability concerns. So it's a convenient source of information about common side effects, dosage forms on common medications but, it's not comprehensive about any truly important subject, and includes a great deal of information that's quite limited utility. If one wants actual reasonably, useful information

about a medication, there are other sources of information that are much better.

Q Dr. Wolfson, you had reviewed some articles concerning the use of anti-psychotic medication, including the use on Delusional Disorders, would that be the case before coming here?

A Yes.

Q I am going to hand you what has been marked as [96] Governments Exhibit 1, –

MR. MARCUS: Mr. Short, you've got a copy of that material.

MR. SHORT: Would that be the same?

MR. MARCUS: Same as (1).

BY MR. MARCUS:

Q Would that appear to be the material you've reviewed?

A (Witness reviewing document.) Yes, it's just like the copy I have.

Q Okay. And based on your review of the literature, what appears to be the trend and treatment of anti-psychotics, – or delusional disorder with anti-psychotics?

A Well, this is quite interesting, because there is a conventional wisdom that patients with delusional disorder respond less to medication, but I have my own serious doubts with, – based on my own experience. The literature mirrors that experience. It shows favorable results in many cases. Most of these are small series of case reports,

but they show good outcome generally, and a few cases the outcome is characterized as excellent.

Q Have you reviewed the Affidavit of Dr. Cloninger?

A I have.

[97] Q And in there, Dr. Cloninger draws some conclusions, and one would be Number 9, saying,

> "Although, neuroleptics are often recommended by physicians for control of agitation, or psychotic symptoms, there are no data to justify this as a benefit to patients with delusional disorder".

Would you agree with this?

A I would most strongly disagree with him.

Q And if we can go to Number 14, in there it says,

> "This would not constitute an adequate trial of the medication in a patient with schizophrenia, but neither does it provide any basis to think he would be an exception to the rule that neuroleptics are not beneficial in delusional disorders".

Now, neuroleptics are the same as anti-psychotics?

A That's correct.

Q Is there such a rule?

A No, there is no such rule.

Q And would you disagree with this statement?

A I disagree with the statement, and I would further criticize it a proceeding statement. Number 8 and 9 as [98] follows, – to go from this one paper, –

> "naturalistic studies not showing a more favorable end outcome between two groups of patients, does not lead to conclusion that there is no evidence that neuroleptics are beneficial for patients with delusional disorders."

What this should have said would be, –

> "There are no large scale double bind, – double blind, placebo control studies providing effectiveness with delusional disorder".

That's the type of scientific information we like to accumulate. It's most likely that impractical to accumulate such information, in such a fashion, for this illness because it's hard to assemble a large series of patients. And the role of paranoid patients in a double blind study is something that I think would be also a bit of an accomplishment. If any of us ever succeeds in doing it, I'm sure we will be well celebrated for it. But that's not the only kind of data that can be. And there is anecdotal data, there is these case report series, including one method analysis, and statistical [99] combination of prior studies, and also on top of it on two differential it's reasonable to consider relief of psychotic symptoms be a beneficial thing.

Q Now, in this particular Affidavit, in paragraph 5 and paragraph 6, he cites to, one a textbook of psychology, or psychiatry, and the other to a study, – I'm probably not going to pronounce it right, – be referred to as Dr., –

A I should find out how you pronounce this.

Q Opjordsmoen and Dr. Retterstol?

A Yes. Well, Dr. Retterstol, is a, – one of the senior people in the field, and I presume that the other doctors, a

colleague of his, – I can pronounce Retterstol's name, but not the other.

Q And, have you reviewed that document?

A Yes, I have.

Q And what is your opinion, as to that document's validity?

A There's no problem with this paper, there's a problem in the way the paper's been applied to today's question.

Q Okay. Can you elaborate for the Court, please?

A Well, what this study sought to do, – there is a long series of studies that Retterstol's has carried out with the population of patients with schizophrenia and [100] other psychotic disorders. And in that, he's tried to categorize their long term course which relates to response to treatment, but is not simultaneous. It is not completely coincident with that question because, not all these patients were treated the same way, and the substantial portion of this cohort of patients were followed prior to the development of anti-psychotic medications in the late '50(s) and early 1960(s). And, the expected question, if delusional disorder responded to medications, as well as schizophrenia, would be that you see higher functioning in patients with delusional disorder who were followed and treated in the years after introduction of the medications. These medications then before, as has been seen with schizophrenia, But, that is making a few assumptions that Dr. Opjordsmoen and Dr. Retterstol are not willing to make and on the last page they pose, – may I just go ahead and quote it?

Q Please.

A

"Another explanation might be that there are more problems with compliance in delusional disorder, than in schizophrenia. Chronic patients are usually very sensitive to all side effects of drugs. And [101] most reports on the effect of neuroleptic and delusional disorder are still anecdotal. Drug treatment in this disorder therefore still seems to be terra incognita. Controlled drug trials are strongly needed. It also remains to be demonstrated if the affect of Pimozide is specific."

These are world renowned experts in this condition, they are unwilling to be dogmatic about the question of treatment response and they recognize one potential, – potentially very important explanation for the discrepancy in long term course, which is that of the patients with paranoia, with delusional disorder, maybe less willing to stay on medication, particularly in rural Sweden, a long way, – a long distance away for doctors, over a period of decades.

Q So it would, be fair to say, – if you're not compliant, – you're not taking your medicine, – you don't get better?

A It's hard to assess the benefit of medication if its still in the bottle and not in the person.

Q You know, Dr. Wolfson, as we get to the bottom of the Affidavit, Dr. Cloninger proposes, –

[102] "According in my opinion, the treatment of Dr. Sell should be limited to basic support and voluntary symptomatic treatment".

In paragraph 19,

"This would include a safe supportive menu, with access to exercise, and reading material".

And it goes on talking about using anti-depressants. Do you believe, in your expert opinion, this would be effective in treating his psychotic disease?

A No, this is an insufficient proposal. If we were having this conversation in 1935, that would be the best I would be able to offer him. But, this is unsupported, perhaps even irresponsible, to advance that as an adequate response, – as an adequate way to address Dr. Sell's difficulties.

Q Thank you. Do you have Government's 1 there?

A Yes.

MR. MARCUS: At this time I would offer Government's Exhibit 1 into evidence.

MR. LAWLESS: Tell me, – I'd like this opportunity to voir dire the witness, if you are talking about these papers, because they don't seem to view what the diagnosis is.

[103] MR. MARCUS: At this point in time, don't have anymore questions, – I mean if –

THE COURT: Government's 1 is a –

MR. MARCUS: This is a of series of papers –

THE COURT: Okay. That's the papers you showed me, okay. Fine. Do you have anymore questions?'

MR. MARCUS: No I don't.

THE COURT: Okay. Then you may obviously, – I'll withhold ruling on the introduction of this, Mr. Lawless, until after cross examination.

MR. LAWLESS: Thank you.

THE COURT: Okay. Mr. Lawless. I won't make this mistake, a second time.

CROSS EXAMINATION

BY MR. LAWLESS:

Q Dr. Wolfson, you have seen Dr. Sell when?

A I beg your pardon?

Q You said that you have seen him for under six hours, it wasn't clear how long you had seen him. When did you see him?

A The lengthy interviews that I can recall, were on the morning after his return to our facility. I do not have with me materials that would specify that date, although they'll be in the records there.

Q Okay, hold on. Is this what you are referring to?

[104] A Yes, the second time.

Q Great.

A And at some point, –

Q When you say "returned to this facility," which time?

A For his present hospitalization. He had been at the facility prior to that time also, and I probably encountered him, but I don't recall. It had been enough years ago, but upon his return back here, – there in Springfield, this would have been April 20th, and I saw him April 21st.

Q Is there a note there?

A Yes.

Q Your note?

A Yes.

Q What does it indicate?

A It states, "Patient wishes to resume customary dose of Paroxetine," –

Q Which is what?

A Paroxetine is an anti-depressant, P-A-R-O-X-E-T-I-N-E, – which he had been taking, prior to his incarceration". And as I recall, it had been interrupted in jail custody, or something like that, because that wasn't automatically renewed upon his return until I saw him and ordered it.

[105] Q Okay. Do you have your notes there?

A Well, they are within this, –

Q No, no, from that meeting on April 21st?

A No. I was not taking independent notes besides what's in the chart here.

Q What's in the chart?

A The chart is, –

Q The sentence you just, that's the, –

A Yes, that's correct, – there's an admit note, written by his attending. But in my role as consultant, that's what I wrote.

Q That sentence you just read?

A That's correct.

Q Nothing else?

A Nothing else.

Q How long did you see him for?

A I was present for the duration of the intake interview, which was typically forty-five minutes to an hour.

Q Do you know how long it was this time?

A No.

Q And the next time you would have seen him?

A If my memory on this is reliable, it was long enough ago that I may not have these in correct order, the next lengthy meeting within, – for which there is [106] career documentation, so that I can specify the date, would have been his due process hearing. However, –

Q You are counting, sitting on the opposite side of the table from him in room as being an interview with him?

A Contact with him, he did speak. He was in front of me for a long time, I was able to observe him. I spoke, I was able to watch his reactions to what I was saying. I would count that as, – as, meaningful time with somebody. Granted there were the distorting nature of the rest of the

circumstances, but I was in his presence. Anyway, what I was getting ready to say was that sometime in between those two documented points that I can read in a short time with him, I had at least one fairly lengthy meeting with him. He had questions about medications, going into psychotic medications, he had questions to ask me about Paroxetine, and other related questions to that.

Q When was that?

A I don't recall exactly, my best memory is that it was within two weeks or so after his arrival.

Q Are there any notes that you took as a doctor, that are in his chart?

A I don't believe that there are, I don't recall making them, and I don't see one, so, –

[107] Q Is this your habit, not to make notes about conversations with your patients?

A Well, let me remind you that I'm a consultant, basically, other than assessments, approaching Dr. Sell about his possible voluntary use of medication. I don't have what I need to be able to work until we have either a form of consent or some substitute thereof.

Q Let me get this, – you were the person that is suggesting the administration of drugs, either voluntarily or involuntarily?

A Yes.

Q Okay. And you are telling us that, – that your practice is to administer the drugs first, and then get to know the person, second?

A No. What I told you, perhaps not as articulately as I might if I had thought about it through further, is that I was not in the role of the individual responsible for generating the majority of the documentation relating to Dr. Sell. I was well familiar with Dr. Sell, and previous documentation had already been developed about Dr. Sell. Had I been his attending, I would have a hand written note from his first arrival there, and the copious other documentation, as I do with the patients whom I attend upon their arrival, to prepare a forensic evaluations. In this role of [108] consultant, when things are happening with Mr. Sell, – Dr. Sell, it would be more reasons to document, frequently, when he is essentially on hold as he has been. For legal reasons, whatever I document is likely to be duplicative to what Dr. DeMier's already writing in the chart, and that's not being consistent with what consultants do in other scenarios.

Q Well, forgive me but my experience says to the contrary, with regard to the documentation, that consulting physicians provide back. Generally, they provide quite lengthy written reports back to the referring physician. But, you have one sentence in that file, that refers to your contact with Dr. Sell before you formed the opinion that he should be medicated?

A I have one sentence, relating to the immediate issue at the time, which was that he wished to continue anti-psychotic, – anti-depressant medication. I also conducted an informed consent discussion with him, which is memorialized on a form that doesn't say very much, and Dr. DeMier most likely took care of the other form that would have to be filled out at that time. I wouldn't equate that with the level of assessment that I carried out. Had I been the attending, there would have been no one else to

write detail notes in the chart, but me, and I would have done that as the consultant.

[109] Q You didn't write any, –

A But the duty falls to someone else.

Q Well, was there another physician present?

A No, I was the only physician present.

Q Now, you have stated here today that, I guess you are unwilling to give a diagnosis, with regard to Dr. Sell, is that right?

A No. I have reservations, and don't want to portray, the diagnosis of delusional disorder, the plausible one as necessarily the correct one. There are some feature of his early course to the extent that we know about it, that would appear inconsistent with that.

Q Such as?

A Well, there a remark in the records from Barnes in 1982, in which it is recorded that he appeared to have had hallucinations, I don't recall the precise phraseology, I can find it.

Q That would be good.

A He had delusions on probably auditory hallucinations.

Q Probably, auditory hallucinations?

A Yes.

Q Of what duration?

A That's not specified, but it was related to his initial presentation, which appears to have been fairly [110] dramatic. My understanding is that he felt that there was a leopard getting onto a bus outside of his office.

Q That would not be an auditory hallucination, would it?

A No, but that indicates a fairly severe dysfunction, a problem with psychotic symptoms. And although, many patients know not to report hallucinations as one clear tangible, sign of dysfunction –

Q What, what –

A – a clue the doctor suspected it. He was correct.

Q What was the source for the claim that he said he saw a leopard getting on the bus? Was that something that he reported himself, or did a third party report it?

A I believe he mentioned something about that, and it's mentioned somewhere else on the copious source investment counselor had, but I did not recall where. There were other aspects of the episode that were reported here.

Q Can I look at that?

A Sure.

MR. LAWLESS: Could I have a moment, Judge?

THE COURT: Sure.

(Pause)

BY MR. LAWLESS:

[111] Q This was in 1982?

A Correct.

Q Okay. Are you aware of any other documentation, regarding hallucinations, from 1982 up to the present time?

A As I recall, this was the only instance where that issue was raised.

Q And that says probably?

A That's correct,

Q All right. Now, for a diagnosis of schizophrenia, don't there have to be prominent hallucinations, – recurrent and prominent hallucinations, isn't that part of the diagnostic criteria?

A That's part of the illness, that's not always part of what the patients will report. And, in particular, Dr. Sell appears to have been able to remain away from psychiatric detention for fairly lengthy periods of time. And certainly, remain away from the kinds of crisis style interventions, such as his 1982 admission Barnes. So, that's a potential distorted feature, related to the second concern that I have, which is that this is a fellow that has displayed very high functioning, at times, and yet is now responding to a serious mental illness. One would have to cause it that he had maintained a delusional picture bearing a [112] delusional concept, where a delusional picture more or less continuously since the onset of his illness until the presentation to us.

Q Delusional.

A Yes.

Q Yes.

A And if that were the case, one has to wonder, how he was able to continue functioning that well. An alternative hypothesis, is that he may have had the illness that was relapsing and remitting, and in episodes where it got worse and then episodes where it got better again. And, that would also fit the notion of the person who presents with serious symptoms and then doesn't have to keep going to the doctor repeatedly, or getting or having the circumstances compel them to have more or less continual contact. If that is what indeed happened to him, back then – I was not there to witness it, then, that would also be discord with the notion of delusional disorder that would suggest a more favorable prognosis, schizophrenia, –

Q Excuse me, pardon me, pardon me. Isn't one of the earmarks, of the difference between a diagnosis of schizophrenia, and delusional disorder, the ability of someone to be able to function, in the rest of their [113] life?

A That is not completely adequate to delineate the two disorders, there needs to be, –

Q You are familiar with the *Diagnosis of the Statistical Manual 4*, of the American Psychiatric Association?

A Yes. Yes, I am.

Q Okay. And it's what your institution uses in making diagnoses?

A I, –

Q Well, do you, – do you rely on the criteria set forth, therefore making diagnosis?

A We make use of the criteria, there. I'm a little uncomfortable with the notion of characterizing is what our institution uses, is some type of a regulatory dictum.

This is a book that is extremely useful in standardizing diagnostic terminology, and our field has certainly profited by it's development.

Q Okay. And with regard to the diagnostic criteria, for Delusional Disorder, doesn't it say, as one of the diagnostic criteria particularly ('C):

> "Apart from the impacted of the delusions, or it's ramifications, functioning is not markedly impaired, and behavior is not [114] obviously odd or bazaar".

A That is one of the expected features of Delusional Disorder.

Q Okay. And with regard to Schizophrenia the diagnostic criteria for that, specifically, Diagnostic Criteria B,

> "Social/Occupational disfunction for significant portion of the time, since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self care are markedly below the level achieved prior to the onset"?

A That is a feature seen commonly, –

Q Yes or No, is that what it says with regard to the diagnostic criteria?

MR. MARCUS: Judge, I'm going to object to him asking, – let him show him the book.

MR. LAWLESS: All right.

THE COURT: Okay. Just, please, Dr. Wolfson, try to answer the questions the best you can, if it's based on, – Mr. Marcus can give you the, –

BY MR LAWLESS:

Q Is that your understanding, what the diagnostic [115] criteria is, –

A Yes.

Q – for Schizophrenia, –

A Yes.

Q – and then I have marked with, I think, my pen, –

A Okay. Okay, yeah, that's what we have here, and to the extent that the book is usable, –

Q All right.

A – and that's what we rely on.

Q Thank you. And, from the history that you have observed and Dr. Sell's file he was employed, up until the time of his arrest as a dentist, is that correct?

A That is correct.

Q And at the time he was arrested he maintained a medical practice, I believe it's at 777 New Ballas Road?

A I don't recall the address, but it's my understanding that he had been functioning well.

Q All right. That's Highway 40/64 and New Ballas, Fairly Tome Medical office building.

A I'm not sure what the name of it was.

Q Yeah, all right, okay. All right, so he was able to maintain himself there, you don't have any mention of hallucinations after the '82 incident that you've talked about. Now, what text do you consider authorative in the area of psychiatry, Doctor?

[116] A There are a variety of textbooks, just about all textbooks have a certain level of flaws. Which text you use depends on what particular question was examining their, –

Q How about for Delusional Disorder?

A I'm not sure I consider any text definitive on Delusional Disorder, they are useful, but it's, –

Q What text would you consider useful?

A There are two books that Dr. Retterstol has published.

Q Retterstol, how do you spell that?

A R-E-T-T-E-R-,

Q I'm a real slow writer, I'm sorry, –

A R-E-T-T-E-R-S-T-O-L.

Q -S-T-O-L. Okay.

A And then just about every text book involving descriptions of psychotic disorder will include some information about Delusional Disorder.

Q Okay. Are there some texts that you rely on in your practice?

A I don't have any single text that I rely on in any standing fashion. I use books, *Comprehensive Textbook of*

Psychiatry, there's an UPI textbook of *Psycho-Pharmacology*, a book by Lashman, L-A-S-H-M-A-N, *Organic Psychology*, another text by Whitaker and Clayton. I [117] don't think of any of them as the one thing that stands out as the source of all the answers, with an entity like Delusional Disorder.

Q All right. With regard to the patients that you've testified to having benefited clinically, I think you talked about three, that would have been what, outside the legal settir g?

A Correct.

Q And, four, one, twice, a total of five admissions, if you were, – now you say they've benefitted clinically. What, does that mean?

A Well, there's an interesting feature here, is this I believe, which gives rise to notion of diminished response to anti-psychotic medications in Delusional Disorder. I have not typically been able to root a patient with Delusional Disorder, – preexisting delusional ideas, the way is often feasible, to do with a patient of Schizophrenia.

Q As far at their hallucinations?

A No, we are talking about delusions.

Q Okay.

A Sorry. Hallucinations either occur not at all or rarely in delusional disorder, depending on, –

Q Right.

A – hallucinations, by whose definition you accept. [118] Regarding, delusions not all patients with paranoid

schizophrenia or other psychotic disorders will have complete remission of delusional material, but many will and that's always the goal. My experience with patients with delusional disorders has been different, and in some ways it was strikingly how similar it was to those reported inside these case reports. The first flaw is to reduce the extent to which delusions inform and determine behavior. Second agenda also needs to be to try to not have a patient's delusional system continue to expand, as some tend to. If that continues without interruption, eventually it will be had to think of them in that box as someone preserved functioning, and although there's fears, that's in the DMS and that's typically happened. What one seeks to do is to support the patient, treat the patient to the point where, –

Q What do you mean by "support the patient"?

A Well, typically all of the patients with delusional disorder, all of them were basically reduced to treatment by some problematic occurrence. None of them came in saying, "I'm ill, I'm in distress, please help me". All were forced, often through interaction with legal system, to be put into a situation, –

Q Okay.

A – voluntary or not, –

[119] Q Okay. I understand, I thought Springfield was probably there because, –

A That's of all of them. That was also of patients at Barnes and the Washington University Clinic.

Q What do you mean by support the patients?

A So, what own wishes to do is to minimize the extent to which the delusions that interfere with their functions.

Q When you say support the patient, that was something as I understood it exclusive of medication, what did you mean by, –

A I did not intend it to be exclusive of medication, it doesn't work without medication.

Q What do you mean by support the patient?

A Once medication is employed, then psychotherapy of a level of sophistication and diplomacy, not ordinarily required of patients with schizophrenia, is of value.

Q Okay. Any treatment prior to the application of medication?

A Well, you do that anyway, with someone in the hospital, it's never really done any lasting good, anything more than momentary comfort, if that, until the medications are used. I mean one doesn't simply put pills in people and ignore them while they are in the hospital. But, I don't want my statement that the [120] psychotherapy is useful afterwards, to be confused with the notion that the psychotherapy is independently helpful. Does that answer your question, sir?

Q No, but that's all right. Dr. Sell is currently in unit 10E?

A That's correct.

Q Okay. And, what is your understanding of why he was placed there?

A He was placed there initially on an administrative separation order, I'm sorry, administrative detention order, by Lieutenant, and he is here now on a clinical observation order, authored by Dr. DeMier.

Q How often is that renewed?

A Weekly.

Q And, I believe your testimony on direct examination, was that it would be absurd for someone in his position to say he was in love with his nurse?

A To not desist in, –

Q What gives you the impression that he didn't desist?

A He kept approaching her, and his remarks, –

Q What was the initial approach, – what, he called her by her first name?

A My understanding that this is probably something that began long before I ever heard about it. So, by [121] the time this information found it's way to me, it had already been an existing problem as it were with him being a, –

Q Okay, well, you're insisting that he persisted in this, and that this is a basis for claiming that he's really just off the deep end. And, I'd like to know exactly what it is you claim he persisted in, because the notes that I've reviewed indicate that he addressed her by her first name, – she said it was inappropriate, – he then said, "you don't seem to like me as much you used to," which may or may not have been a reference to the fact that he had asked her to serve as his staff consultant at the hearing. And it was

only afterwards when he was locked up that he made any statement about loving her, to supposedly some guard in 10E. I don't see anything in her complaint that talks about that?

A My understanding, from what I can recall having heard at the time; was that there was an escalating pattern of over familiarity, merely obnoxious looking at first. What I find striking, about it is that, –

Q What, I would like you to look at the documentation for your conclusion, that, I'd like you to review that record, there, right now, and point me to the documents that support what you're drawing your conclusion from?

A Some of what I recall is not in the documents here.

[122] Q Where is it?

A Information is shared with us verbally, in morning meeting, every work day, we have informal interactions with nursing and correctional staff, –

Q There are nursing notes in there?

A There are nursing notes in there. Not everything that they tell us, –

Q There are correctional officer notes in there?

A At variables.

Q There are doctor's notes?

A There are doctor's notes.

MR. LAWLESS: Can I look at that for a moment?

(Pause)

BY MR. LAWLESS:

Q This is an incident report, dated July 24th of this year, is that right?

A That's correct.

Q It says,

> "Inmate came to nurses station for aspirin, he wanted to continue talking with this writer, and I told him I didn't have time. He stated, "You never have time for me anymore, I'm not special anymore". [123] He proceed to tell this writer, "You just don't realize what you mean to me". Inmate was given a direct order to leave, that his behavior was out of line. He then stated, "I can't help myself". He has approached this writer in the past and stated, "Hello, Michelle". He has been reprimanded before for his inappropriate behavior towards this writer."

So apparently, you can't call nurses by their first names, is that right?

A That's a breach of the carum, at least on occasional circumstances, it has implications beyond that.

Q As I understand, in the institutional rules, developing any kind of relationship with a nurse, viewing them as someone who is helping you or assisting you, that's wrong too?

A There's nothing wrong with helping or assisting, but a nurse in any setting, not merely a correctional setting, is a treater not a friend, and it's like I said it probably maybe innocuous, fairly innocuous, mildly undesirable in some circumstances, with potentially part [124] of a greater concern, as it was here.

Q Perhaps he confused being a doctor with being a nurse, but I don't think there is nothing wrong nurses being friendly with their patients.

A I'm sorry was that a question, sir?

Q No. The incident report prior to that is that Dr. Sell was in the pill line without water. Is that right?

A Yes.

Q Okay. And then he was directed to get water and return, he did not but remained in the line making a personal comment to the nurse about the appearance of her teeth. Okay. He told her, "she had nice looking teeth". "I shut the door," – he is a dentist, right?

A Dr. Sell?

Q Yes.

A Yes.

Q When he returned, he said that, "I was a result of poor breeding". And that's referring to a male, is that correct?

A That's correct.

Q I assume from the incident report, that the person wrote it understood what he meant?

A No, the person that wrote it is a psychologist. So, if the doctor read it, I would hope that he would have understood.

[125] Q Okay. And that's Richard Fredrick?

A That's correct.

Q Okay. And then there's Dr. Sell's version of the event?

A Actually, there are two versions. One version would be here (indicating), – and on that occasion he denied ever speaking to Dr. Fredrick, at all, ever in his entire life.

Q Okay. That was not written by him?

A No, this is, – each incident report is investigated by on of the correctional supervisors, a Lieutenant, and they take a statement, and memorialize the statement here along with what they call relative facts. And then in addition, if the incident report is sustained and forwarded on the unit disciplinary committee, then there is an opportunity for the prisoner's statement to be memorialized again. And if it goes from there to the disciplinary hearing officer, then there would be yet another occasion on which his statements are taken down.

Q Is this statement that's attributed to Dr. Sell endorsed by him in here or not, by him in any way?

A I beg your pardon?

Q Did he sign it?

A No.

[126] Q He wrote a statement, saying, in fact, that Dr. Fredrick slammed a door in his face, is that right?

A I haven't read the statements, so I guess I shall. (Witness reviewing document.) I'm sorry, your question again?

Q In his version that he wrote out there in his own hand, he stated that Dr. Fredrick's had slammed the door and it came to Dr. Sell's face, is that right?

A Yes, with such violent force that he felt the glass window door would shatter in his face.

Q Those are the instances of his escalating familiarity with the nurse, telling her she had nice looking teeth and then saying she didn't have time for him anymore?

A I would not characterize those as being the totality of the information. That's the totality of the documentation accessible to us here. At the time he was receiving the incident report, I then heard retrospectively that there had been a pattern of increasing familiarity, something which in his case would lead to substantially greater concerns, than it might just in a vacuum.

Q Concerns of what?

A Well, the investigative materials that we got, prior documentation, showed a tinnitus pattern of [127] pursuing a problem or concern, repeated letters to the Dental Board, letters complaining to public officials, just not letting go of a problem. I remember it much more, more in this way, but they believe in the materials are in the statements from some of the witnesses, –

Q Witnesses to what, I'm sorry?

A To his initial Federal case I believe, I don't recall which particular investigative material I saw this in, but there was a concern about familiarity, a sort of warm inclusion his office staff, beyond what you may see in some offices, and then bill verification of one staff member. Problems with boundaries and that can be a concern in

somebody who is paranoid, someone that has already been accused of attempting to arrange for the murder of one federal officer, now has another federal officer he's idealizing apparently, with whom he is seeking to smear out, make more a morphosis boundaries in role. Talking about wanting to use her as a model for her teeth, which it mentions, –

Q After, his release it says.

A – after his release, which is also against regulations, but more importantly, is, –

Q But what, what's against regulations?

A – Him having social or occupational contacts with [128] staff members after his release. I believe the recommendation is two years, but, –

Q But he hasn't been convicted of anything, you mean to tell me if he was found not guilty or released, that he can't talk to whomever he wants?

A It's an issue of the people who he would be talking to, should be maintaining contact with him. I don't know of any sanction that would be imposed upon him, –

Q All right.

A – or calling or writing, but it's inappropriate for, more or less to nurture that type of thing.

Q Okay. But he's the one that's in 10E?

A That's correct.

Q Okay. Has there been any discussion with him, regarding progressive plans for him to get back into general population?

A I'd have to defer to Dr. DeMier on that question.

Q Okay. That hasn't been part of these informal discussions, that don't appear in his record?

A I'm sure it has been, my perspective on it that his best chances for going back out to population and succeeding, without further problems, will be at such a time that he is treated and this whole subject will get much easier to cope with. While we have an untreated illness, which appears to be in more problematic [129] condition, than it was when we met for his due process hearing. I don't anticipate things getting better, until a meaningful intervention is made, which is what we would like to do.

Q So, essentially what you are saying is, that from your view is that unless he is medicated, he is going to stay in 10E?

A I don't know that I have to hold that position programmatically, but I would like to see him medicated and not on that unit, our best way to help him and to alleviate the situation without having to deal with escalating risk.

Q And he had been there twice before, and not having to be put into 10E then, right?

A He'd been here twice before, and he's been through locked units, because everyone we admit arrives in them, and I do not recall him ever being moved back, to a locked unit before.

Q Okay. In fact, that was only after a determination was made on your part, that he should be medicated, that his condition was viewed as escalating and he was placed in to 10E, isn't that right?

A It's no surprise for his condition to escalate if it's not treated, but yes, the order in which that happened, if you wish to conceptualize it that way, this [130] problem developed well after the issue of medication was raised, several weeks.

Q Right. Now, I had a, – I don't know that I have another copy of that, –

THE COURT: This, Exhibit #1?

MR. LAWLESS: No, sir. I'm sorry, I have this marked as Defendant's Exhibit A.

THE COURT: This.

MR. LAWLESS: Yes. I was just thinking about this.

THE COURT: Thank you.

BY MR. LAWLESS:

Q And that is a report from the, – another Federal medical center, is that right?

A No. It's from the Metropolitan Correctional Center, basically, a Federal jail, in Chicago, it's not a medical center.

Q Okay, all right. Are females treated there for medical problems?

A Well, females are confined there, and if they have medical problems that aren't too serious to be held, they are transferred to local hospital, then they would be kept within in side the parameter. What I recall is that, Chicago has a small infirmary and a couple of cells with

monitor, – with the capacity for monitoring [131] people, –

Q Okay, just looking at the first paragraph of the report, doesn't it indicate that a Magistrate Judge here in the Eastern District for Missouri referred this person to the Bureau of Prison for forensic alveolation and it was the Bureau of Prisons that designated her?

A That's correct. That they do have a forensic psychologist there and they do forensic studies. But, it is not a medical center.

Q Okay. So, they did a forensic study there, and in the body of this report, turning your attention, –

> "This person is diagnosed with, – is suffering from delusional disorder, and at page seven under prognosis, the third sentence it indicates, – "Individuals who suffer from a delusional disorder often do not respond to mental health intervention,"

is that what it says?

A That's what it says.

Q All right. And then on page eight, the paragraph that starts at the bottom of the page,

> "As noted in the prognosis section, delusional disorder does not [132] typically respond to pharmacological intervention or psychotherapy".

And, you disagree with that, I take it?

A Well certainly, I have a basis for disagreement with it.

Q And you disagree with Dr. Cloninger, on the basis that he has for saying that?

A I disagree with the legal reasoning, that Dr. Cloninger makes in his Affidavit to go from abstinence to the kind of systematic double blind, placebo trial studies that we like to have, and which we have are more disorders, and after schizophrenia to go from there, to the notion of withholding treatment, for a condition that's been demonstrated in our experience and in the literature to respond to treatment.

Q Do you know Dr. Cloninger?

A I trained at the University where he was a member of the facility, not personal friends, or anything like that.

Q I would assume you wouldn't call a personal friend irresponsible?

A Well, at least not in court. The statement is what's irresponsible.

Q And, the portion of Dr. Cloninger's Affidavit that you found problems with again, if you could go over that [133] with me?

A Yes, I have it.

Q Good, so do I. Can you tell me what, –

A Oh, what the problems are, right, sure. I thought you were going to ask the questions.

Q No. I want to try to understand your statement.

A Okay. Well, I mean there are several problems, but I would present the key one as follows: There is as I said, a

leap for reason is the most appropriate way to put it, from the Opjordsmoen and Retterstol study, showing that a cohort of patients followed currently in the direction of neuroleptic medication,

Q Your are citing this part of the Affidavit here?

A Item seven.

Q Okay.

"Yet there appear the effected the neuroleptics in the treatment of schizophrenia as well as established some reports indicate that at least Pimozide may be effective in delusional disorder as well. In this article, a long term follow up of seventy-two first admitted patients with delusional disorder is described. Outcome in the group [134] admitted during 1946 to '48 was compared with that of patients admitted during '58 to '61. We did not find a more favorable outcome in the group admitted after the introduction of neuroleptics."

A Yes.

Q Okay.

A And Dr. Cloninger believes from that research finding to a statement in the next item,

"There is no evidence that neuroleptics are beneficial for patients with delusional disorder."

That can't be justified and, in fact, that you can see easily yourself, that at the beginning of paragraph seven, he mentions,

"Some reports that at least Pimozide may be affective in delusional disorder."

Pimozide, is a neuroleptic medication, so there is a contradiction right there, within that seven lines.

Q It says some reports indicate that, however this study, of seventy-two patients indicated that there was nothing more favorable after the introduction of neuroleptics?

[135] A Yes. And from there it goes to, there is no evidence. There is much more evidence out there than he cited. But he already cited evidence.

Q All right. Now, you are familiar with the appeal that Dr. Sell filed from the hearing?

A I was actually not the person to consider it, so I know that he filed an appeal and I glanced at it. I've not painstaking read through the entire, composition, –

Q You, he discussed that with you and the, –

A Well, he told me that he'd written it intending for me to read it rather than the person judging the appeal, which is another concern, about unrealistic understanding of a situation. And if he wishes, I hope to read the whole thing at some point, but there is a, if not painstakingly gone through the entire exposition it's a document that was intended, or should have been intended, for the administrator hearing the appeal.

Q Well, it certainly was written to them also. But, in there he cites the sixteenth edition of the *Merc Manual*, of diagnosis and therapy. Okay. Are you familiar with the *Merc Manual* on diagnosis and therapy?

A Yes.

Q Okay. And it's just a general, – it would be like a medical dictionary?

A It's a little more fancy than that. But, it's not [136] a definitive text for any of the specialties that are encompanied, – that are encompassed, within general practice.

Q Okay. However, it does state that as a general rule, treatment of delusional disorder with drugs is not the treatment of choice?

A I don't recall if it says that particular thing or not, I imagine it probably has, – includes the same misconception or extension of the differential manor in which psychotics tend to respond to delusional disorder, as did Dr. Greenstein, as does Dr. Cloninger here. Those of us who treat these patients, of course, see that they do respond. They respond differently, and it's more a complex and more difficult undertaking.

Q Okay. Your testimony, is that the delusions themselves, respond to medication?

A No. My testimony is that, the, – first the delusions stop expanding, when treatment works. It's even conceivable that some delusional material may regress. For example, one of the patients had been convinced that there were people coming into her attic, and then some months after treatment started she conceded that, – well, maybe there might have been squirrels in the attic. But, to continue with this illustration, the notion that her neighbors had been [137] harassing her and looking through her mail slot, wanting to steal the mantel piece clock, that never went away. However, she stopped believing that they were still trying to do it, she stopped having

her behavior become influenced by these beliefs. She did not engage in a further wrestling match with the sheriff over the shotgun that she had, which is what had brought her to medical attention. So, then, woman in their fifties don't usually engage in such behavior, so our first goal was to diminish the impact on her actions and her judgement of the illness. Second, was to minimize the expansion of the delusional system. That's was accomplished, and it's typically been my experience to be accomplished with other patients. It would be nice if, as one often does with schizophrenia if the person would say, "You know, I've realized that my thoughts were distorted and that must not have happened that way". And, it's not realistic to be able to accomplish that with patients with delusional disorder. Now, that truth, which turns out once I've searched the literature to be more widely understood than I'd realized, has gotten mangled into the notion that, patients don't respond. They respond differently. And in terms of the specific likelihood of abolishing a particularly delusional belief, rather than lessening it's impact, [138] than in that manner, anti-psychotic medications have a lower rate of effectiveness.

Q Okay. The documents that you've identified, – endorsed here in Government's Exhibit #1.

THE COURT: One. Do you need to get it?

MR. LAWLESS: No sir.

THE COURT: You've got it?

MR. LAWLESS: I think so.

BY MR. LAWLESS:

Q Okay. Do you have those in front of you, sir?

A They are in this stack here I can find it.

THE COURT: Here you go.

THE WITNESS: Actually, Your Honor, I'd prefer to use mine.

THE COURT: Okay.

THE WITNESS: Since mine are a little more, – here they are.

BY MR. LAWLESS:

Q Okay. I don't know if ours are in the same order, but, the first one I have here says, monosymptomatic hypochondriacal psychosis manifesting as delusions of parasitosis, is that, –

A Yes.

Q Okay. Now in the DMS-IV, it makes note that hypochondriasis is to be differentiated from delusional [139] disorder, does it not?

A Yes. As we used those terms in 1995 or 1997, yes.

Q They are different?

A They are representations of different concepts.

Q All right. And, what is monosymptomatic hydraclorineal, – (blah, blah) (laughter)

A Hypochondriacal, –

Q Great.

A Well, this paper was published in, –

Q What is that condition?

MR. MARCUS: I'm going to object. He's trying to answer the question the best he can, your Honor.

THE COURT: Okay, all right. Go ahead.

THE WITNESS: Okay. Seeing as this paper was printed in 1978, and the modern form of the DSM, which began with DSM-III – the third edition, DSM-III, in 1980, hadn't even come out yet, this is terminology for what today would be classified as variative delusional disorder. So long as one were cautious enough to make certain that it simply wasn't someone with hypochondriasis.

Q Hypochondriasis is what?

A Hypochondriasis is a persistent non-delusional, non-psychotic, but perhaps obsessional preoccupation [140] with one's state of health, physical health typically.

Q Fearing that one has a serious illness, that one, in fact, doesn't have?

A Usually several serious illnesses.

Q Well, okay, when it says monosymptomatic, I think that means one symptom, is that right?

A Well, I think that what the real meaning of this was that, this was somebody with delusions confined to one realm, just as you described when you are, –

Q Okay. And hypochondria, as we understand it is someone who always thinks they're sick?

A Yes.

Q Okay. Dr. Sell doesn't think he's sick, does he?

A No.

Q Okay. And, I haven't had an opportunity to review these since we were just given them in the court today, but when you look at this, it says, "Report of cases, one is of a woman who thinks she has insects crawling all over her body, and she thinks she has a parasitic infestation," is that fair?

A Yes.

Q Okay, that's case one. In fact, she didn't have a parasitic infestation, right?

A Well, more than that, she had a delusional conviction that she had a parasitic, – not alleviated [141] by comfort or reassurance, that's without the transiently working out, with real hypochondriacs.

Q Okay. And then case two, is a seventy year old person, who thinks they've got fleas?

A Yes.

Q Okay. And case three is a fifty-six year old woman who complains of an insect infestation in her house?

A Yes.

Q And case number four is a twenty-nine year old man, who probably had a genuine attack of pubic lice, which was treated successfully, however he then developed itching all over his body, –

A Well, –

Q – shaved off his hair?

A – he bought a microscope, –

Q To look for insects, okay. Thought he was sick. But those are all different, in kind, from the delusion that you are talking about with Dr. Sell here. These are all people having delusions with regard to themselves, and things happening to them in their own little body, are they not?

A No. I wouldn't say that they are different in kind, they are different in content.

Q You don't differentiate hypochondria from delusional?

[142] A For a psychics symptomatology in general, typically in the form of the symptoms are more important than the content. Let's take hallucinations as an example, just because it's the most tangible one. If someone is hearing voices, it is less important whether the voices are your mother-in-law or some public figure, and more important that they are hearing voices. Sometimes the content then will direct itself to problematic things. The same thing is with delusions. If you have delusions it's a problem. It interferes with function, the particular interference may relate to the content of the delusions, but the key feature to catch on to it first, is that there are delusion present that shouldn't be.

Q Okay. So you didn't differentiate between God talking to Moses and someone claiming that the devil told him to kill somebody?

A That isn't really a fair correlation to what I said. That opens complex problems about differentiating peoples religious views from psychotic symptoms. We can address in depth if we had more hours, and its, –

THE COURT But, we don't.

(Laughter)

THE WITNESS: As it happens with something to deal with, with considerable level of sophistication sometimes. What I'm saying is that before someone gets [143] hung up on the specific delusional content, the first fact to recognize is that delusions are present, and that in itself is a clear signal of abnormality. Once one is satisfied that they are truly delusions. These particular conditions that relate to these case reports have been grouped together with delusional disorder of the persecutory type, as appearing to have important commonologies. To the point that they are presently thought of as being different subtypes of the same illness. Sure it's different to deal with someone who thinks the government wants to destroy him, than it is to deal with somebody who thinks they have fleas, and is harming themselves with shampoos or shaving off all their hair. Their practical management on a day-to-day basis is different, but the illnesses appear to be similar, possibly the same illness if this is a unitary entity.

Q So you would be looking at this comparing this with the semitic type of hallucinational disorder as opposed to the persecutory type?

A That's correct.

Q And when you have people that feel they are being persecuted, who are paranoid, okay, would placing them in isolation tend to exacerbate that condition?

A Might conceivably, transitionally improve it, to [144] the extent that they are away from others, they are away from activity. Dangerous things often tend to happen

when they are at liberty to get into situations where trouble follows.

Q And you don't think there's any danger in 10E?

A 10E doesn't completely eliminate the possibility of danger, –

Q Isn't it rife with danger from staff?

A Rife with danger from staff?

Q Right?

A I can't see where you are coming from, there, certainly not rife with danger from staff.

Q All right. Inmates there are not, brutalized in an effort to administer medication to them?

A No. And we don't brutalize inmates period. That's not a way for anyone to be able to finish their career, in corrections with their retirement. It may be a way for them to live in our facility instead of work there.

Q The second paper that you talk about here, this Pathological Jealousy, I guess you would say, that it's a jealous type of delusional disorder?

A Parallel concepts, different terminology, from different eras.

Q Okay. Under today's criteria, would that be what would be called the jealous type, that's a subtype of [145] the delusional disorder?

A Yes. And actually, just give me a minute to find that citation. Are, you talking about this one (indicating)?

Q I wasn't holding it up, but that is what I was looking at, yes.

A Yes.

Q Okay. And the next one I have, again talks about the treatment of monosymptomatic hypochondria, that's –

A Byron (phonetic) Monroe.

Q Right.

A Yes.

Q Okay. So again, that's about the semantics subtype of delusional disorder, is that right?

A Yes.

Q Okay. And then the next paper you have is by, again by Monroe, is that right?

A There were three by him. Which journal is it?

Q Well I just have one, that says delusional disorders, I can't tell what, –

A It would be down at the bottom of the page.

Q *Psychiatric Annuls* from May of '92, is that what you have?

A Yes, I believe so. Yes, and the *Psychiatric Annals* on this page.

[146] Q Okay. And then they talk about the misdiagnosis of delusional disorders, sometimes as being schizophrenia?

A Yes. That certainly is a potential problem and analogy, so is the reverse.

Q You have little idea of the frequency of the delusional disorders? And they talk in, – in here it talks about treatment with this Pimozide, for the somatic subtype, jealousy and then I think it's the erotomania subtype, is that right?.

A Yes.

Q Those are the subtypes he is discussing?

A I would imagine that those are probably the subtypes for which he has access to patients who will stay in treatment without being cohersed.

Q Okay. And then the next paper that I have is from *Comprehensive Psychiatry*, is that right? Is that the next one you have?

A Yes.

Q Okay. And that's Delusional Disorder Paranoia. And there in treatment, which appears on what, reprint of page 517, is that right?

A Yes. We are in treatment of contact of antipsychotic drugs, neuroleptic drugs.

Q Well, they say,

> "Most patients in the study had no [147] treatment, but seven had psychotherapy and five were given neuroleptic drugs, right"?

A Correct.

Q "Of the seven who were given some kind of psychotherapy, three were considered improved at the time of discharge," is that right?

A That's what it says.

Q Okay.

"And follow up however, one of these was clearly chronically ill. Thus two out of the seven were considered improved at discharge, and at least socially recovered at follow up. Of the five patients who were given neuroleptic drugs, three were considered improved at discharge. Of these three, there was no follow up in one, and another the patient was clearly chronically ill after a follow up at six months, and the third, after a follow up of two to three years, the patient was at [148] least socially recovered."

A Correct, it says that.

Q Okay. And then the last one we have here is the Nostalgic Validity of Paranoia is that right?

A I think we skipped another one, but that's correct.

Q Well, it could happen, I'm not, maybe I don't have it.

A I hope you have it, I brought you a copy.

Q Well, these are all of them that I have.

(Pause)

MR. LAWLESS: Ah, there it is. Successful. Treatment of Litigious Paranoia.

THE WITNESS: Yes.

BY MR. LAWLESS:

Q Okay. Here we have an eighty-five year old man brought into the hospital for psychiatric treatment, is that it?

A Yes, in handcuffs.

Q In handcuffs. Tried to demolish his sons house with an ax, claiming it was his property, and was charged with trespassing, intentional damage and disorderly behavior, had no medical, psychiatric or forensic history, is that right?

A (No verbal response.)

Q At age eighty five?

[149] A Yes.

Q Okay. That's an unusual age for the onset of delusional disorder?

A The problem with delusional disorder is that it is difficult to be sure when the onset is. These patients both in a series, I frequently read about at the turn of the century, tend to stay away from doctors longer than just patients with any other disorder until some precipitating event, like demolishing a house, compels it. Conventional wisdom is that on average, the illness is present for five years before initial presentation, but there is a broad range. I think Kragle had some patients who had been retrospectively, he was determined they had been sick for a long as nine years. So, it's hard to be sure, but it's certainly an unusually old, elderly age, to be presenting.

Q Okay. And then they treated this, – was there a diagnosis with this person?

A I don't recall exactly where in here they discussed diagnosis in the clinical setting before they initiated treatment. Although, they did mention that the pattern of intense litigation and started forty years before, when he

was forty-five. I guess that might conceivably lead one to conclude that the onset of those troubles was sometime during that period.

[150] Q Okay. Litigious paranoia. Okay. And so, they treated this person with this anti-psychotic medicine, right?

A Yes, they did.

Q And then, in their treatment, – first paragraph, the last sentence they say,

> "Whether or not Pimozide has this specific therapeutical affect on delusional disorders, suggested by Monroe remains to be seen."

They talked about tension subsiding at first, and that tension, there are other drugs available that can reduce tension, are there not?

A I think that that's not the main point of their statement. The question here deals primarily with specificity, that Pimozide is opposed to other anti-psychotic medications.

Q Okay. And it says,

> "Little by little interpersonal relationships, social and occupational functioning improve, but full incite never develops and the original conviction never completely disappears, although it ceases to influence their actions."

[151] Is that what he is saying?

A That's what he says, and if one made that just a little less dogmatic, it would represent my own views pretty well.

Q Okay. So to the extent that Dr. Sell has what you would call fixed false ideas, those ideas are not going to go away?

A They probably will diminish but not resolve. I certainly would not offer him that expectation, as I would someone with schizophrenia, or with psychotic symptoms from some other cause, that one can expect complete remission. That's what you always try for.

Q And then, I'm sorry, I just want to make sure we're on the same page, what is the last article you have there?

A I don't know where I put it in here, – it's by Kenler, –

Q Yes. Kenneth S. Kenler. And they go on to say that any definitive conclusions from the studies is impossible?

A They relate that to the lack of physical control group, which is the same consideration that I referred to earlier.

Q Right. Anecdotal reports were located claiming that patients with SDD responded to a combination of [152] neuroleptics and was it Triclocide (phonetic) antidepressants and lithium?

A Yes.

Q Okay. But they were unable to make, – draw any conclusion that they were willing to sign their name to?

A No, they were unwilling to portray this as definitive proof of these medications, being proven to be superior to the placebos. That's how I interpret their statement. There's a reason, in general we are cautious

with anecdotal experience, because there could be a multiplicity of factors, –

Q Could be misdiagnosed?

A I have less of a concern of that for these series they've quoted, but that's a problem with this illness, both potential with under-diagnosis and certainly with over-diagnosis.

Q All right. And as I understand Dr. DeMier's testimony, there hasn't been any other treatment attempted with Dr. Sell, to this point?

A Incorrect. Dr. Sell remains on the anti-depressant that he was taking, –

Q He was taking that all the time?

A Yes. Which he considers to be of benefit, and potentially may be. It may be that he would have further deterioration or further impingement of mood [153] disturbance as well, if he were not. I'm certainly not going to stop it just to find out if he does or not. And to the extent that's it's feasible to have a supportive relationship with his attending, which is sometimes a difficult endeavor in our facility, given the lack of confidentiality, that's being provided to him also.

Q That's being provided to him by his attending, –

A Clinician.

Q – clinician. Putting him in segregation, where he's locked down twenty-three hours a day in isolation? That's your testimony? That's how they're building a bond between each other?

A Well, I think you are putting words in my mouth, sir.

Q No, I'm just looking behind your words, at the reality, so that we can get some of that out here.

A Well, I would not agree with that characterization.

Q Is that where he is, is he in 10E?

A That is where he is.

Q Is that where he is locked down twenty-three hours a day?

A That is where his circumstances compelled him to be placed until something is done, –

Q Is that where he's locked up?

[154] A That is where he is.

Q With no break, contact during the day with anyone else, he's in isolation?

A He is not in isolation. He is not in physical contact with other people; there is traffic past his door, although, –

Q What is his door? What's this door made of?

A The door is made out of steel, with a glass window peaker vent.

Q So, it's not bars, it's a speaker?

A Right. Grilled if I need to talk to him, it's perforated.

Q Okay. He eats his meals in his cell?

A Correct.

Q He's taken out of there to take a shower and for recreation?

A That, and interviews with staff.

Q Okay. And we'll just have to trust Dr. DeMier's testimony as far as the frequency of his meeting with Dr. Sell?

A I see no reason not to trust Dr. DeMier's testimony about the meeting, – frequency of the meetings with Dr. Sell. I trust him whatever it was.

MR. LAWLESS: Okay. I don't have anything else.

[155] THE COURT: Mr. Short.

MR. SHORT: I just got a few questions Judge.

THE COURT,: Okay.

MR. SHORT: Good afternoon.

THE WITNESS: Good afternoon.

CROSS EXAMINATION BY MR. SHORT:

BY MR. SHORT:

Q You do know Dr. Cloninger?

A I've spent some time in his presence in educational lectures, when I was in training. I don't know him personally, particularly well.

Q And you were at Washington University, when?

A I attended medical school there, for the second portion of medical school, after I got a Master's degree

from the University of Chicago. I transferred into the third year class there and that was in 1985, graduated in 1987, and I did my residency in psychiatry in Washington University at Barnes Hospital, from then until 1991.

Q All right. So Dr. Cloninger was a professor of psychiatry at Washington University when you first came there?

A He was a professor of psychiatry, and in particular, had some teaching duties relating to one of our formal rotations at Jewish Hospital, which I did my [156] second year and then he became chairman while I was at the university.

Q Yes. In fact, he was chairman of the Washington University Psychiatric Department?

A He was for a time.

Q Yes. That time was five years?

A I don't remember the exact time, but I know that he left prematurely, but I don't recall the exact duration.

Q And I gather by those two cute comments, you mean something other, than, you have some problem, –

MR. MARCUS: Judge, I object to, –

MR. SHORT: Let me finish the question, you got some problem with the reason he left?

MR. MARCUS: May I make an objection now? There has been a continuous comment, – there's a little bantering going on through this doctor's testimony, I think he's due the respect he has as a doctor, as any witness in this courtroom is due, and I haven't objected to this, – I

don't want to disrupt the flow of this proceeding, but it's getting to the point where I think it is disrupting the flow.

MR. SHORT: Well, one of the problems, Judge, is the witness can't answer the question.

THE COURT: Okay. Why don't we just proceed forward here. We probably just, – although he may be [157] having troubles, Mr. Short, Mr. Lawless did also. I think, you know, you are getting the answers, maybe not as quickly as you like, but you are getting them, so let's just proceed in as civil manner as we can, while making the points we need to make. So, you may proceed Mr. Short.

MR. SHORT: Thank You, Judge.

BY MR. SHORT:

Q Was he the head of the department of psychiatry while you were there?

A He was head of the department of psychiatry for the second half of my residency.

Q Okay. Are you Board Certified?

A Yes. In both general psychiatry and forensic psychiatry.

Q When did you receive your M.D.?

A 1987.

Q All right. You would have used a couple times of respect to Dr. Cloninger's Affidavit, the term "leap of logic," or "leap of reasoning," correct?

A Yes.

Q Would you agree with me that you would be guilty of a leap of logic or a leap of reasoning if you were to diagnosis Dr. Sell as having an erotomania subtype of delusion? Based on that nurse incident?

[158] A Well, I haven't diagnosed him as having an erotomania subtype. It's a developmental phenomenon that's potentially of great concern. But, I haven't rushed to diagnose him with that subtype. And regarding the Affidavit, I have no choice, it gives me no joy but they're conclusions that don't connect.

Q Okay. But you're not telling Judge Adelman that you think the Dr. Cloninger (sic) suffers from some kind of erotomania subtype of delusional disorder are you?

MR. MARCUS: Dr. Sell.

MR. SHORT: Dr. Sell.

THE WITNESS: I don't know that Dr. Cloninger suffers from any disorder at all.

BY MR. SHORT:

Q Dr. Sell, you know what I meant.

A No, what I had a concern, that you were seeing a phenomenon that could potentially go some place undesirable. I have not specified this as being an erotomania subtype. In one sense it may not be fitting cleanly into any subtype, which is an additional grounds to perhaps question the diagnosis all together.

Q In fact, if I understand, your testimony, when you answered the questions of Mr. Lawless, that you've told Judge Adelman, that you would prefer to defer a definitive diagnostic conclusion and you preferred not to [159] be

pinned down on the medication to administer to Dr. Sell. Correct?

A Yes. I said those things.

Q Now, you know we're here to have Judge Adelman eventually make a decision as to whether or not involuntary medication should be administered to Dr. Sell, correct?

A Correct.

Q And you told Dr. Adelman, you can't tell, – Judge Adelman, you can't tell him what you want administered at this time?

A I can tell him that the various choices are, depending on which potential properties of the medications involved are more or less appealing to Dr. Sell. I plan to give him some flexibility in what he receives. If he refuses to cooperate, – if I'm given an order to treat and he refuses to cooperate with treatment, that will tie my hands as to using the medications I would most prefer to prescribe. So, the actual drug that is prescribed will depend on, in part, the circumstances at the time. I can give you a good summary of what the potential possibilities are, as far as the choices of medication.

Q But as you stand here now, you are not going to tell the Judge Adelman what you intend to administer?

[160] A I see no benefit to saying, "I will pick this drug now," dogmatically, if it turns out that Dr. Sell prefers Quetiapine to Olanzapine, than there is no reason why he shouldn't have some input. I don't see a need to dictate that much to him without, enough is being dictated to him as it is.

Q You also told Judge Adelman that it's your opinion that you can restore Dr. Sell to competency, correct?

A Precedent, with similar cases, would suggest that, yes.

Q And that's regardless of what medication what medication you eventually choose?

A It's regardless what medication, it's regardless of the quotable diagnosis.

Q Okay. And how long is that going to take?

A That I can't predict, it's ranged from as long as, – as short a period of time as a few weeks, which I would certainly not expect in this case, up to months.

Q And you understand that you do not get months, and months, and months to deal with this question, do you understand that?

A In some cases we have been given months, and months, but we're given commitments in increments of four months at a time, and usually without particularly adversarial proceedings, second four month of expanded [161] extension so that the period of extends to eight months, it has been offered in our patients who needed it. In a few cases where, then after going back to court, the District Courts have ordered further treatment for additional commitments. It depends on the circumstances of the case, and how much optimism I can offer as to further treatment having benefit.

Q Could months extended to over a year?

A The longest that this has ever gone on with the defendant, was probably about two and a half years, but

that's highly unusual. The majority of the people who we restore, we do it either within the four month period or we do it within the four month period with the form of an extension.

Q You also said that you believe that whatever medication you eventually choose, it would make him less violent, correct?

A I think it would reduce the risk of violent could behavior, at least whatever risk of violent behavior might be related to manifestations of his illness.

Q Because he couldn't get any less violent, now could he?

A I beg your pardon?

Q He couldn't get any less violent could he, he hasn't been violent at all?

[162] A We are holding him in a place where it's hard not, if not actually impossible, but very difficult for him to do anything violent. But, there appear to be some things in the recent past that are of great concern, including to his charges.

Q Well there wasn't violent in the time he was in open population was it?

A No, he wasn't. That's why he remained there.

Q So he can't get any less violent than he's been in Springfield?

A What I think we would like to see, –

Q Can he? Answer my question. Can he?

A He has not been immediately violent in front of me, so no, in his current supervised surrounding he has not been violent.

Q He hasn't been violent immediately or otherwise, has he?

A No, as from reports his conduct in jail, elsewhere, –

Q I said at Springfield?

A Not at Springfield.

MR. SHORT: That's all I have.

MR. LAWLESS: I don't have any redirect.

THE COURT: Okay. You may be excused Dr. Wolfson, thank you.

[163] THE WITNESS: Thank you.

THE COURT: Mr. Marcus, do you have any further witnesses?

MR. MARCUS: I don't have any further witnesses. At this time I would re-offer Government's Exhibit 1 into evidence.

THE COURT: Any objections to Government's Exhibit 1.

MR. LAWLESS: It doesn't seem real relevant to me, but, just being in front of you, – well you can figure that out on your own.

THE COURT: Why, don't I just take it for what it is worth as far as value is concerned, so I will accept it into evidence for those purposes only. And that is the

extent of the testimony you want to present, Mr. Marcus, is that correct.

MR. MARCUS: That is correct, your Honor.

THE COURT: Okay. Mr. Lawless or Mr. Short, I have the Affidavit of Dr. Cloninger which I'm going to, accept as if it were presented in this Court on this proceeding. Is there anything else you'd would like me to take notice of, any other evidence you'd like to present?

MR. LAWLESS: I have what I have marked as Defendant's Exhibit A, I'd move for it's admission.

[164] THE COURT: Okay. And it will be so admitted. That's the report from the Chicago Medical Center by Dr. Greenstein, correct? Yes.

MR. LAWLESS: We need some time to confer with our client, Judge, he was not available to us until this morning.

THE COURT: You may do that.

MR. LAWLESS: Yeah. We do need to do that, and I apologize to the Court.

THE COURT: Okay. How much time do you think you need, half hour?

MR. LAWLESS: How much can I get?

(Laughter)

THE COURT: You know, –

MR. LAWLESS: Half an hour would be fine.

THE COURT: Okay. Fine.

MR. LAWLESS: Thank you.

THE COURT: We will be in recess for half an hour.

MR. LAWLESS: Thank you.

(Temporary Recess from 1:00 p.m. Until 1:40 p.m.)

THE COURT: Mr. Lawless, or Mr. Short, are you prepared?

MR. LAWLESS: I'd like to call Dr. Sell.

MR. LAWLESS: Good afternoon, Dr. Sell.

[165] THE WITNESS: Good afternoon.

DR. CHARLES THOMAS SELL, DEFENDANT, SWORN
DIRECT EXAMINATION

BY MR. LAWLESS:

Q I'd like to ask you some questions concerning Michele Goldberg?

A Yes sir.

Q Okay. She is a nurse at the Federal Medical in Springfield?

A Yes, sir.

Q Do you know her?

A Yes.

Q There's been testimony here today about you making statements to a correctional officer that you "loved her," did you ever make those statements?

A No. I did not say that I loved her, I said I liked her.

Q All right. And that conversation concerning Ms. Goldberg, that took place in the 10E unit?

A Actually, it was 10A, unit but it was still a lock down unit before they moved me to 10E.

Q Okay, did, –

A They are very similar.

Q – you initiate that conversation or did the correctional officer initiate that conversation?

[166] A I did not initiate the conversation, the correctional officer came to my cell door, and initiated the conversation. Asking me why I was being locked down.

Q And, –

A Then I said I guess it was because of Nurse, Goldberg, –

Q Okay.

A – to the best I know, although I didn't know for sure.

Q All right. Did anyone speak to you prior to your being locked down, about your conduct towards her being possibly inappropriate?

A No. Never.

Q Okay. If they had brought that to your attention what would your response have been?

A I would have completely avoided Nurse Goldberg.

Q Did you mean to harass her?

A No, sir.

Q Okay. Do you love her?

A No, I don't love her.

Q Do you fanaticize, – pardon me go ahead?

A (No verbal response.)

Q Do you fanaticize about her in anyway at all?

A No.

[167] Q Okay. There was testimony that you referred to her by her first name?

A Yes.

Q Had you heard others do that?

A No.

Q Okay. Have you observed her on occasion to be flirtatious with others?

A Yes.

Q Okay. Have you observed others to be flirtatious towards her?

A Yes.

Q Okay. Was that prior to any contact you may have had with her?

A Yes.

Q Okay. Did you, – compared to that other behavior, did you feel that there was anything about yours that was out of the ordinary?

A No.

Q Okay. And, the incident that you were cited for, that eventually lead to your being placed in lock down, that took place approximately a day after notice was filed here regarding, – seeking judicial review on the issue of involuntary medication?

A Precisely. I was locked down on the Saturday, July 24th, and the appeal here to this Court was filed on [168] July 23rd.

Q Okay. You are, – before you were transported up here today, you were living in, what's called 10E?

A Correct.

Q And, you had been there for approximately two months?

A Yes.

Q Okay, And that is an isolation area?

A Yes.

Q You are housed by yourself in an isolation cell?

A Yes.

Q How many hours a day are you there?

A I'm there twenty-four hours a day, except for five days a week, when they take us outside. They put us in these big cages or pens about sixteen feet by thirty-five

feet, and when we are not, – on the other two days a week they take us to the showers.

Q All right. Now there's been testimony that there is a window that's built into your door?

A Yes.

Q Can you see a portion of the hallway from that?

A Yes.

Q Can you hear what's going on in the hallway from there?

A If people are screaming loud enough.

[169] Q Okay. You can't hear normal conversations of people going by?

A No. That little perforated screen he talked about must be built from the 1930's and it's totally clogged with dust, so there really isn't very much sound waves that goes through the screen, it's pretty well muffled. But, if you yell loud enough you can communicate with other prisoners through the vents and the sound will travel, if it's loud enough, through the steel door.

Q Is your cell clean?

A No, it's filthy. They say that we are allowed to clean it, but in reality, all that matters is them handcuffing you and making you get back, and then they push a mop, which is already dirty, because they use the same dirty mop water, and then we can mop and then push that back out. But, there is no way for us to sweep. So all the dust and all the dirt and all the filth, just stays in there

and all we can do is push a mop around, with dirty filthy mop water in it, which really doesn't accomplish anything.

Q Okay. Have you observed any insects or rodents in there?

A Yes. I have observed ants, and I've observed cockroaches.

Q Okay. Any rodents?

[170] A No, –

Q Okay.

A – not at that jail.

Q All right. You say you are able to hear loud noises out in the hall?

A Yes.

Q Okay. Well, there was testimony by Dr. Wolfson, that, I believe he is not aware of any physical abuse of inmates by staff. Have you witnessed any of that while you've been in 10?

A Yes, I've witnessed several brutalities, and beatings on numerous occasions. For example, –

Q Where did they take place?

A Okay, one of the first ones I witnessed, was – what they enjoy doing is putting in a very violent psychotic, – actually he's a Chippewa Indian named Rostoak, they put him in with a Jamaican with dreads named Ellis, a dread Jamaican, and as Ellis was being walked out handcuffed, Ellis said, "No, I don't want to go in there, I don't want to go in there with him, that guy is violent," and the guard

said, "You don't have a choice, you're going in there with him, whether you want to or not." And so, they put both of them in together and then when they took their handcuffs off of both of them, they were locked in this pen sixteen feet by [171] thirty-five feet. And then the guards all left the yard, and went inside. Well, as soon as they went inside the Chippewa Indian ran up to the Jamaican and smacked him in the head and tried to grab his cigarettes from him, and the Jamaican held onto his cigarettes and a fist fight ensued. And the Jamaican was really just trying to defend himself, but he was much bigger than the Indian and they kept fighting and fighting, as if two Roman, – ancient Roman gladiators fighting to the death, while all of us prisoners stood there horrified, screaming, "Guards, guards, please come back out. Please come back out". And they wouldn't come back out until the Indian had his scalp all open and blood was pouring everywhere. And, finally, they came out, and they dragged the Indian away and they beat down the dread Jamaican, named Ellis, and then they dragged, –

Q When you say "beat him down," how?

A Well, they rushed him into the back of the pen and kept hitting him 'til he fell down, because the Jamaican was upset screaming, "It wasn't my fault. It wasn't my fault," and they were all screaming and then they just knocked him down, and then they handcuffed him and chained him up and dragged him out. And, we were just all standing there looking at each other, you know like, "What the," – you know, I mean, you can imagine, it was [172] extreme violence. I'd never seen anything like this in my life. Where two people were put into a cage as though they were dogs, with the guards knowing that there was going to be a fight, I wouldn't even think that should be

legal for animals, to encourage them to be this way. But the guards were joking and laughing about it, and of course, we were talking about for at least two weeks after that happened, and there was the blood, wasn't even removed, blood stains are probably still there. What was your question again?

Q Were there any comments, immediately afterwards by the guards?

A Yes, they said, "Next time we're going to bring out coke and popcorn for all you prisoners to watch the entertainment".

Q All right. Now that was a fight between two inmates, –

A Yes.

Q – have you observed any inmates being brutalized by guards?

A Yes, I have. An inmate named Scott, who is also from Jamaica, was beaten by a guard named Evans, as he had his hands cuffed behind his back, as he was coming back from the showers, because Evans just said – oh he slipped and fell, and when your hands are cuffed [173] behind your back you've got no way to stop your fall. But, what was happening is, he beat him, he knocked him down, – he hit him, and knocked him down, and Scott was screaming, and Evans was screaming, and Evans kept kicking him and kicking him and kicking him, as Scott was trying to crawl into his cell to get away from the kicks. And, then as he was almost completely in his cell, but his leg and his foot was still hanging out, Officer Evans continuously slammed the steel door onto Scott's foot. And you can, – if you get his medical records, his treatment for

that foot injury will be documented. Also, I've observed other Mexican and, – I don't know if he's a Mexican or Cuban, but I know there was an inmate that for at least two weeks had a huge, like a hole, in his head that the doctor kept coming out everyday and treating, and I asked him, and he said that was a blow that he had received from one of the guards. Also, that same inmate, Ellis, he's been beaten coming back from the showers, too. They really hate Ellis, because Ellis is fighting taking the psychotropic drugs, he doesn't want to take it. And, so he's got his lawyer, that's appealing it to the courts right now. They really hate it, they do everything to make someone take it, to get out of there.

Q Has anyone come to you with any kind of a plan for [174] your being released from 10E, based on an improvement in what they deem as problems in your behavior?

A No. Dr. DeMier always told me that he wasn't the one keeping me in 10A, every time I talked to him, he said it was somebody else. When I asked anybody else, or he'd, – like the officers, the officers said, "It's not us keeping you in 10A, it's Dr. DeMier". Dr. DeMier would always say, "It's not me keeping you in 10A it's the officers". So, he would purposely try and make me think that other people were keeping me in there.

Q Okay, so there was nothing suggested as far as improvement in your behavior, that would result in your getting back in general population?

A No. Never.

Q Okay. Other, than the Competency Restoration Group, that Dr. DeMier testified to, have you received

anything else in the way of psychological or psychiatric counseling or treatment, since you've been there?

A No. The Competency Restoration Group was, to me, trying to instruct perhaps people with very low intelligence, or, if I may use an old phrase, mentally retarded people, so that they would know the difference between a prosecuting attorney and a judge. I know the difference between a prosecuting attorney and a judge, so I would sit there and sit there, and listen to this.

[175] Q Okay. I think we got an idea of what the class was like from Dr. DeMier. But other than that, there's been nothing else that's been afforded you or tried with you?

A No.

MR. LAWLESS: Okay, I don't have anything further.

THE COURT: Okay. Mr. Marcus.

MR. MARCUS: Good afternoon, Dr. Sell.

THE WITNESS: Good afternoon.

CROSS EXAMINATION

BY MR. MARCUS:

Q I just have a few questions for you. Has anybody physically abused you in this 10E unit?

A Not physically, but verbally.

Q Has anybody beat you?

A No.

Q So, the acts that you've described, that happened to this Jamaican and this, – as you characterized it, Chippewa, that's never happened to you?

A No.

Q Okay. Let's talk about nurse Goldberg, just a little bit.

A Yes sir.

Q Initially, Dr. Sell, you wanted her to be your rep in the hearing, and, –

[176] A That's correct.

Q – and for whatever reason, she couldn't do that?

A She agreed to be my representative, and we got started going on that and then the social worker came and told me that she had been transferred to a different ward altogether, and that she would no longer be available to work with me.

Q Okay. Now, did you feel Nurse Goldberg was your friend?

A Not a friend, but I felt that I could trust her. I wouldn't say a friend, but I would say that she was an acquaintance that I felt comfortable with.

Q And you testified on direct sir, that you believed that she was flirtatious with other prisoners?

A I wouldn't use maybe the word "flirtatious," so much as friendly. I would observe other prisoners talking to her for probably a half an hour, joking and laughing, and just passing the time.

Q Did any of the other female nurses have this type of demeanor, as Nurse Goldberg had?

A No.

Q So, as you perceive it, she is the only one that had this overly friendly demeanor?

A I never said it was "overly friendly".

Q Now, on direct examination, I believe your counsel [177] asked you if she was flirtatious, and you said, "Yes"?

A Yes, she was flirtatious, more so than the other nurses.

Q Okay.

A But I never said she was overly friendly.

Q Okay. Did you feel she was flirtatious with you?

A Well, I don't know if I would use the word flirtatious with me, but I think we did a lot of fun things together.

Q And did you feel because of this relationship, and the fun things you did, that you had more of a special relationship with her as opposed to any other nurse?

A No.

Q Now, I believe Mr. Lawless asked you if other patients called her by her first name, and I believe your answer was, "No," is that correct?

A That's correct.

Q Did you ever address her by her first name?

A There was one time when I addressed her by her first name, she said she didn't like it and I never addressed her by her first name again.

Q Did you ever tell the guards, or tell Nurse Goldberg, that you were in love with her?

A No sir.

Q Did you ever make the comment that "I didn't touch [178] her, but I would if she would have let me"?

A To who?

Q To either the guards or to the nurse, or to the psychologist?

A No. I might have said something to one of the guards once that I didn't touch her.

Q Did you ever follow that comment up with the following phrase, "I didn't touch her, but if she had asked me I would"?

A I may have said that if she wanted me to touch her, but she never wanted, – she never asked me to touch her, and I never did touch her.

Q Did you think there was some point in time where she might want you to touch her?

A No.

Q Why would you even raise that question, that you would touch her if she asked, you knew that was an inappropriate behavior within the institutional setting, correct?

A No, I did not. No one ever told me that it was inappropriate behavior for me to touch another person.

Q You mean it's okay within the institutional setting for you to have physical contact with the female nurses?

A No one ever said it was inappropriate for me to actually touch another human being within the [179] institution. I never did touch Nurse Goldberg, but I don't feel it would be inappropriate if we happened to touch.

Q Did you ever tell either a guard or a nurse or an inmate, that you were in love with her and you couldn't help yourself?

A No.

Q You never used that phrase, "I can't help myself"?

A No, Not in, – no.

Q And, just so I make sure I understand what you are saying, you don't feel it would be wrong to have physical contact with a female staff, because no one told you that it was wrong?

A What do you mean by "physical contact"?

Q Touching.

A You mean like if I were to shake her hand?

Q I'm not talking shaking hands.

A Well, that's what I interpret touching, as to actually, physically touch another person. What do you interpret touching as?

Q Let me clarify, –

A Yes, please do, because I don't think we have the same definition as to touch.

Q So, if in fact, you have, –

A Can we look it up in the dictionary and see what [180] the definition of touch is in the dictionary?

Q Dr. Sell, please, – please listen to the question, okay. Let me rephrase it if it will help you, all right. You indicated that you that you may have told another guard or somebody, that you didn't touch her, but if she had asked you to, or let you, you would have?

A If she wanted to take my pulse, I would have allowed her to take my pulse.

Q So that comment only was concerning medical needs, pulses, listening to your heart, –

A I don't think pulse is a medicine. Pulse is a touching or a palpation. If Nurse Goldberg, wanted to palpate me, which is a medical terminology, I would have let her. Is that what you are referring to? I don't understand what your question is, frankly.

Q Okay. I think you've answered it, –

A Touching to me is like when I'm doing dentistry on a person, I physically touch them, that is part of the healing arts. A doctor physically touching someone, a nurse physically touching someone, is this what you are inferring to.

Q I'm asking you what you thought.

A I thought that it would mean conformity with a nurse wanting to touch me or me touching a nurse so she could see if I was warm or not, in a medical sense.

[181] MR. MARCUS: Well then, you've answered my question. Thank you, that's all.

THE COURT: Thank you. Anything further?

MR. LAWLESS: No.

THE COURT: You may be excused, Dr. Sell. Thank you.

THE WITNESS: Thank you.

MR. LAWLESS: We don't have any further evidence, Judge.

THE COURT: Okay. What I'm going to do is probably take notice of the whole file.

MR. MARCUS: Pardon me?

THE COURT: I'll take notice of the whole file. Would you like me to do that?

MR. LAWLESS: I'd like to get a transcript of this if I have a post-hearing brief, if I could?

THE COURT: Yes, I think that would be a good idea. Why doesn't somebody order it.

MR. LAWLESS: I'll order it.

THE COURT: Okay. And I'll authorize it, if I have to. If you want to make it expedited we can do that. Whatever you want to do. Makes no difference.

MR. LAWLESS: Okay.

THE COURT: Whatever you want to order. I don't know if it counts against your budget, –

[182] MR. LAWLESS: Yes, it, does, we have to pay out of our budget for it now.

THE COURT: Okay. Well, whatever you want to do. I'm sure either one of you need to order it, so –

MR. MARCUS: We could split the cost.

THE COURT: Or I order it on my own. That would be an idea.

MR. MARCUS: We could work something out, I'm sure. I'd like to get a copy, also.

THE COURT: Okay. And I don't care if it's expedited or not.

MR. LAWLESS: Okay.

THE COURT: Fine.

MR. LAWLESS: Thank you, Judge.

MR. SHORT: What do we want to do then about, –

MR. LAWLESS: When we get it, I guess, –

MR. SHORT: – timing after it's received?

THE COURT: Well, I would like, – obviously, I'd like to have some post-trial briefs.

MR. SHORT: Should we just wait until received, and then, –

THE COURT: Why don't we wait until it's received and then you all, –

MR. MARCUS: Figure out, –

[183] THE COURT: Yeah. Or I'll contact you, or you can contact me.

MR. MARCUS: Thank you, your Honor.

MR. LAWLESS: Thanks, Judge.

THE COURT: We'll just it keep moving along, though, that I do want to do, all right. We'll be in recess, thank you.

(Temporary Recess at 2:10 p.m.)

I, DEBORAH CARTER, do certify that the foregoing is a correct transcript from the electronic sound recording in the proceedings in the matter of the United States of America versus Charles Sell.

11/10/99 /s/ Deborah Carter

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. CHARLES THOMAS SELL, Defendant.	)	No. 4:98CR177DJS 4:97CR290DJS (Consolidated) (Filed Aug. 9, 2000)

MEMORANDUM AND ORDER
OF THE UNITED STATES MAGISTRATE JUDGE

This matter is before the court on the government's motion to involuntarily medicate the defendant using anti-psychotic drugs. The government further requests that the defendant's period of commitment be extended while the defendant is involuntarily medicated. On September 29, 1999, the undersigned held a hearing on the motion. Based on this hearing as well as other matters detailed below, the undersigned makes the following findings of fact and conclusions:

Background and Findings of Fact

On May 16, 1997, defendant Charles Sell was charged in a complaint with making false representations in connection with the payment of health care services in violation of 18 U.S.C. § 1035(a)(2). On that same date, the defendant was arrested and afforded his initial appearance. On May 20, 1997, the government

filed a motion for psychiatric examination of the defendant to determine his competency to stand trial. The motion states that the defendant has a history of mental illness, and is described by his employees as irrational and prone to angry and violent outbursts. On May 20, 1997, a magistrate judge granted the motion and the defendant was sent to the U.S. Medical Center for Federal Prisoners at Springfield, Missouri, for an evaluation.

On July 2, 1997, a psychiatric evaluation report was received from Springfield, and on July 15, 1997, a hearing was held to determine the defendant's competency to stand trial. At the hearing, the court, without objection, considered the psychiatric evaluation report from Springfield. The report concluded that the defendant was currently competent to stand trial, but that there was a possibility that the defendant could, in the future, develop a psychotic episode, and that his paranoid personality characteristics would color his relationship with his counsel. Based on the report, the judge found the defendant currently competent to stand trial. On July 30, 1997, an indictment was returned against the defendant and his wife charging them with fifty-six counts of mail fraud, six counts of medicaid fraud, and one count of money laundering.

Six months later, on January 22, 1998, a petition was filed alleging that the defendant violated his conditions of release by attempting to intimidate a witness. Based on this petition, a warrant was issued for the defendant's arrest. On January 23, 1998, the defendant was arrested and brought to a magistrate judge's courtroom for his initial appearance. At that point, the defendant was out of control, screaming, shouting, and

using racial epithets. Because of the defendant's out-of-control behavior and at the request of the U.S. Marshals Service, the judge attempted to conduct the initial appearance in the Marshal's secure area. As the proceeding commenced, Dr. Sell began screaming and shouting personal insults at the judge and, as the judge started to advise the defendant of his rights, the defendant spat directly in the judge's face. In the judge's words, the defendant appeared "totally out of control."

On January 26, 1998, a bond revocation hearing was held and shortly thereafter, the defendant's bond was revoked and he was ordered detained. One factor considered by the judge was the report of a psychiatrist who was seeing Dr. Sell as a part of Dr. Sell's conditions of release. The psychiatrist reported that, as of January 21, 1998, Dr. Sell's mental condition was worsening. He said that Dr. Sell was not sleeping at night because he was staying up guarding his doors because he was expecting the FBI to "come busting through the door." The psychiatrist said that while Dr. Sell was not an immediate danger, this status could change at any time and Dr. Sell could become a danger. He said Dr. Sell needed to be treated with anti-psychotic medications.

On April 23, 1998, the defendant was charged in a second indictment with one count of conspiring to murder a witness in his fraud case and conspiring to murder an FBI agent who was working on the case, four counts of attempting to murder two separate witnesses in the case, and two counts of attempting to murder an FBI agent.

During the next several months, this matter was set for trial on multiple occasions, but was continued at the

request of both parties. The defendant appealed at least two matters to the Court of Appeals during this time period. On February 10, 1999, the defendant filed a motion asking this court to hold a hearing and determine whether or not Dr. Sell was competent to proceed to trial in this matter. The motion stated that in the opinion of Dr. Sell's psychiatrist and psychologist, Dr. Sell was not currently competent to proceed to trial. On February 22, 1999, the undersigned granted the government's separate motion to have Dr. Sell examined at the Springfield Medical Center to aid in the determination of the defendant's competency to stand trial. On April 14, 1999, the undersigned held a hearing to determine Sell's competency. Based on the evidence presented at that hearing, and without objection from the defendant, the undersigned found that the defendant was presently suffering from a mental disease or defect rendering him mentally incompetent to stand trial, particularly finding that the defendant was not competent to assist properly in his defense.

On April 14, 1999, based on this finding, the undersigned determined that Dr. Sell was incompetent to stand trial, and ordered that Dr. Sell be hospitalized for treatment in the U.S. Medical Center for Federal Prisoners for a period not to exceed four months to determine whether there was a substantial probability that the defendant would attain the capacity to allow his trial to proceed.

In June, 1999, an administrative hearing regarding the involuntary administration of anti-psychotic medication was held at the U.S. Medical Center for Federal Prisoners. Pursuant to this court's order, defendant's counsel was allowed to participate in the hearing. In

July of 1999, based on findings made by the hearing officer, the involuntary administration of anti-psychotic medication was authorized by the institution.

On August 20, 1999, the undersigned granted defendant's motion for a judicial hearing to determine the propriety of the administration of anti-psychotic medication, and stayed the administration of the medication by the institution pending the hearing. The undersigned also granted the institution's request to grant a 120-day extension of his commitment to Springfield. As stated, the hearing was held on September 29, 1999. The evidence, as submitted at the hearing by the testimony of a psychiatrist and psychologist from the Springfield medical center, as well as the affidavit of the defendant's psychiatrist and other defense exhibits revealed the following:

Dr. Richart DeMier, Ph.D., is a staff psychologist at the Medical Center for Federal Prisoners, Springfield, Missouri, and has been so employed for approximately five years. Dr. DeMier is the staff psychologist primarily responsible for the diagnosis of Dr. Sell's illness and for the day-to-day treatment of Dr. Sell. He has been in at least weekly contact with Dr. Sell, both during his first admission to the hospital, and during his most recent commitment in April, 1999. In addition to very frequently seeing and talking to Dr. Sell, DeMier also receives frequent reports from the staff of the medical center who are in daily contact with the defendant.

Based on these interviews and other information, Dr. DeMier has concluded that Dr. Sell is suffering from delusional disorder of the persecutory type, a very serious and potentially dangerous psychosis. Dr. DeMier

also concluded that the defendant's judgment is very poor and becoming worse each day that he is not treated with anti-psychotic medications.

As evidence of this deterioration, in July, 1999, Sell formed an infatuation with a female nurse on the staff of the medical center. He told the nurse that she was very special to him, and that the nurse did not realize how much she meant to him. When told that it was inappropriate to talk to the nurse in this familiar manner, he did not stop the familiarity, and told the nurse and other staff members that he could not help himself, and that he could not stop this conduct. Although he did not touch the nurse, he said that he would do so if she asked him, and the nurse considered him to be a danger to her safety. He also told staff members that he could "smell" the nurse's presence. During this same time, the defendant also told DeMier that he was afraid to be transferred to a county jail because he was certain that the FBI was actively involved in a plan to have him murdered. He also told DeMier that DeMier would be ordered to release him from custody so he could go to Bosnia with his army reserve unit, as this was essential to the national security. He also told DeMier that DeMier would be personally called before Congress to explain his mishandling of Dr. Sell's case.

Because of Sell's specific focus on the nurse, his increasing personalization of the perceived murder plot by the FBI, his personalization of animosity toward DeMier along with the defendant's history of committing an assault on a federal judge, and the fact that the defendant was charged with conspiring to murder an FBI agent and two witnesses in his case, DeMier concluded at the September 29, 1999 hearing, that the

defendant was an immediate risk to commit violent acts, and was dangerous to himself and to others. DeMier said that because Sell believes that people (including the FBI and DeMier) are out to get him, given Sell's mental condition, Sell is likely to "protect himself" by harming people who have no intention of doing any harm to him. The fact that Sell's delusional beliefs have become more focused makes Sell an immediate risk of violence to himself or others.

Because of this danger, Sell is being held in the most secure area of the Springfield medical center, and is allowed out of his holding area only for short periods of time. Although this ameliorates the defendant's danger to himself and the staff, it does not eliminate this danger because the staff still must have contact with him.

DeMier also believes that, based on his training and experience, the only treatment that will improve Sell's condition is the use of anti-psychotic medications, because there is no other effective treatment for the illness. He further believes that if Sell does not receive anti-psychotic medication, his condition will continue to deteriorate. However, if anti-psychotic medications are administered, it is likely that the defendant will be restored to competency, and that the danger caused to the staff by Sell's condition will be greatly reduced.

DeMier has treated two patients in the recent past for delusional disorder with anti-psychotic medications, and both treatments were successful. One of the patients was restored to competency, and the other patient was greatly improved and rendered not dangerous to the extent that he was released from prison. DeMier also

believes that the benefits of using anti-psychotic medications greatly outweigh any risks, and that the use of these medications is the only way to render the defendant not dangerous and to restore him to competency. According to the medical literature, anti-psychotic medication is the treatment of choice for delusional disorder, and delusional disorder responds favorably to the use of anti-psychotic medications.

Dr. James Wolfson, M.D., is a staff psychiatrist at the Springfield medical center and is the consulting psychiatrist on Dr. Sell's case. Based on his interviews of Dr. Sell, and his review of the medical center's records, it is Wolfson's opinion that Sell is psychotic, and that the only way to treat Sell's condition is with anti-psychotic medications. Without this treatment, Wolfson believes that Sell's condition will continue to deteriorate. Further, based on Sell's history and conduct, Sell is currently dangerous, and anti-psychotic medications will greatly reduce the risk of violence by Dr. Sell, and will render him not dangerous.

Dr. Wolfson has treated 1,000 to 2,000 patients with anti-psychotic medications, and has achieved good results in a great majority of these cases. In addition to rendering Sell less dangerous, Wolfson believes that there is a good chance that Sell can be restored to competency by the use of anti-psychotic medications. In the recent past, Wolfson has used anti-psychotic medications on five patients with delusional disorder, and has been successful in restoring four of these patients to competency, an eighty per cent success rate.

Further, Wolfson vehemently disagrees with the defendant's psychiatrist, that anti-psychotic drugs are

not effective and should not be used in the treatment of delusional disorder. Wolfson says that the medical literature, his own experience, and the very experts relied on by the defendant's psychiatrist, show that anti-psychotic medications, when combined with psychotherapy, are effective in the treatment of delusional disorder. Further, even the defendant's psychiatrist agrees that anti-psychotic drugs are effective in the control of agitation and dangerousness in patients with delusional disorder.

According to Wolfson, there are three main side effects involved in using anti-psychotic drugs. The first is tartive dyskinesia and/or distonic reaction. This side effect causes a person to have involuntary body movements of various parts of the body. This is not a permanent side effect, and this condition can be ameliorated by the use of other medications along with anti-psychotic drugs, or by switching from one anti-psychotic medication to another anti-psychotic medication. The side effect is not life threatening, and as stated is not a permanent side effect, but will go away with the use of other medications or withdrawal of the medication.

Another side effect is that some patients are somewhat sedated by the medication. With newer drugs, this side effect occurs infrequently and can be alleviated by changing the dosage of the medication. Further, because one of the purposes of the medication is to allow patients to assist effectively in the preparation and defense of their cases, Wolfson uses medications that do not significantly sedate the defendant or impair the ability of the defendant to assist in his own defense.

According to Wolfson, the other major serious side effect from the medication is neuroleptic malignant carcinoma which can be fatal. Of the 1,000 to 2,000 patients Wolfson has medicated with anti-psychotic drugs, none have developed this syndrome, and Wolfson has seen this complication occur only twice during his career. According to the medical literature, this condition occurs in about 1 in 10,000 patients who take the medication. Further, Dr. Wolfson desires to medicate the defendant with newer drugs, which have a much lower side effect profile than older medications.

It is also Wolfson's opinion that the only way to treat Sell's condition is with the use of anti-psychotic drugs, and it would be irresponsible and wrong not to use these medications. Without these medications the defendant will continue to suffer from a catastrophic and debilitating illness, from which he is never likely to recover. For all of these reasons, Wolfson believes that the benefits of using the medication far outweigh any risk from the medication in any patient he would treat for this illness, whether or not the person was incarcerated or institutionalized in any way.

At the conclusion of the hearing, both the defendant and the government requested permission to delay briefing the issues presented at the hearing until after a transcript was prepared. After requests for more time to file the memoranda by both parties, the briefs were eventually filed before the court at the end of January, 2000. Almost simultaneously with the filing of these memoranda, on January 31, 2000, Sell's attorneys filed a motion for relief from involuntary commitment stating the he was being illegally held at Springfield beyond the time permitted by the statute, and requesting that he be

immediately released. Further, in partial response to this motion, the government filed a motion for the extension of Dr. Sell's commitment to Springfield on February 3, 2000.

On March 20, 2000, the U.S. Medical Center for Federal Prisoners wrote the court asking that Dr. Sell's commitment be extended. Included in the report is a report from Dr. DeMier on Sell's mental condition. The report states that Sell's condition has deteriorated to the extent that the risk of physical injury to the staff and to Dr. Sell has become greater because of Sell's increased volatility and paranoia. Dr. DeMier also states that Sell's infatuation with the nurse at the facility has worsened to the point that his thoughts about her have outweighed other issues that should be much more important to him. DeMier described Sell' behavior as volatile because it can change suddenly without any apparent reason. In summary, DeMier concludes as follows:

> Anti-psychotic medication remains the only effective treatment for his mental illness. Without the opportunity to treat the defendant, he will continue to suffer from a debilitating and catastrophic illness, and we are placed at increased, even inevitable, risk of harm to the defendant or those charged with his care.

He further states that the use of anti-psychotic medications will provide the defendant with a good chance of being restored to competency.

Conclusions

Based on the above facts, as well as the law stated below, the undersigned orders the involuntary medication of Dr. Sell. In the case of *Riggins v. Nevada*, 504 U.S. 127 (1992), the court stated as follows:

> Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings, Nevada certainly would have satisfied due process if the prosecution had demonstrated and the district court had found that treatment with anti-psychotic medication was medically appropriate and considering less intrusive alternatives essential for the sake of Riggins' own safety and the safety of others.

504 U.S. 127, 135.

Further, in *United States v. Morgan*, 193 F.2d 252 (4th Cir. 1999), the court stated as follows in ordering the forced medication of a pretrial detainee because the detainee was a danger to himself and others:

> The fact remains, however, that the finding that treatment with anti-psychotic medication was necessary to render Morgan competent to stand trial was accompanied by a finding that such medication was necessary because he is dangerous to himself and to others at Springfield. Although Morgan provides us with no psychiatric evidence supporting a conclusion that the dangerousness finding was made arbitrarily, he essentially requests that we disregard that finding so that we may evaluate the constitutionality of permitting Springfield medical personnel to make the determination of whether to forcibly medicate him solely for

> the purpose of rendering him competent to stand trial. This we are unwilling to do. We realize that forcibly medicating a pretrial detainee on the basis that such treatment is necessary because he is dangerous to himself or others in the institutional setting might have the incidental effect of rendering him competent to stand trial. However, if such an occurrence would come to pass in the present matter, Morgan would not simply be thrust into the courtroom for trial without additional procedural protections. Rather, he would be statutorily entitled to have a district judge conduct a pretrial examination of his competency to stand trial in the context of an evidentiary hearing at which time he would be represented by counsel and permitted 'to testify, to present evidence, to subpoena witnesses on his own behalf, and to confront and cross examine witnesses who appear at that hearing.' Morgan could be brought to trial only if the government proved to the district judge by a preponderance of the evidence that Morgan was able to understand the nature and consequences of the proceedings against him and to assist properly in his defense . . . Assuming that the government succeeded in this regard, Morgan may be entitled to even further procedural protection should the government forcibly plan to medicate him at any point during trial. Specifically, due process would require the district judge make findings as to the need for and medical appropriateness of such medication during trial. The district judge might also ensure the medication posed no significant risk of altering or impairing Morgan's demeanor in a manner that would prejudice his

> capacity or willingness to either react to testimony at trial or to assist his counsel.

193 F.3d 252, 264.

In *Papantony v. Hedrick*, 215 F.3d 863 (8th Cir. 2000) (a civil case filed by a prisoner at the Springfield Medical Center which the Court of Appeals construed as a *Bivens* action for damages) the court ruled as follows in rejecting the claim:

> A government official is immune from a *Bivens* suit unless the official's conduct violates a clearly established constitutional right. In Papantony's case the right is far from clearly established. In fact, Papantony as a pretrial detainee likely has no substantive due process right not to be forcibly administered anti-psychotic drugs to render him competent to stand trial. *See Riggins v. Nevada*, 504 U.S. 127. Finally, although we reject any remedy for Papantony at this time, circumstances could change and anti-psychotic drugs might eventually render Papantony competent to stand trial. If that occurs, this decision will not foreclose a future argument by Papantony that forced medication during trial violates his right to a fair trial. *See generally United States v. Morgan*, 193 F.2d 252 (4th Cir. 1999).

Given the above law, the undersigned concludes that the government has made a substantial and very strong showing that Dr. Sell is a danger to himself and others at the institution in which he is currently incarcerated. In addition, the government has shown that anti-psychotic medication is the only way to render him less dangerous, and that the serious side effects of the medication will be ameliorated by newer drugs and/or

changing of the drugs. Further, the benefits to Dr. Sell of using the medication far outweigh any risks, the use of such medication is necessary, and a strong showing of the necessity to use this medication has been made by the government. In addition, as in *United States v. Morgan, supra*, an ancillary effect of the use of the medication, because Dr. Sell is dangerous, is that there is a substantial probability that Dr. Sell will be returned to competency.

In *United States v. Weston*, 206 F.3d 9 (D.C. Cir. 2000), the court held that even if a court finds that forced medication is necessary and essential to the defendant's safety and the safety of others, the court must also consider the need for the medication in restoring competency, and the effect of the medication on the defendant's ability to assist in his defense. In the case now at bar, the record reveals that anti-psychotic medication is the only way to render the defendant both not dangerous **and** to make him competent to stand trial. If Dr. Sell is not medicated, he will continue to suffer from a catastrophic and debilitating illness, will remain incompetent, and remain a danger. According to Dr. Wolfson, if the defendant is medicated and receives psychotherapy along with the medications, his delusions will diminish to the extent that they will no longer control his thinking and actions. Given this, Dr. Wolfson's opinion is that the defendant has a good chance of becoming competent and less dangerous. Because the defendant's delusions will no longer control or dominate his thoughts and actions, the undersigned concludes that if medicated, the defendant will be able to communicate with his counsel in a rational manner in order to assist in his defense. Further, Dr. Wolfson intends to

use atypical anti-psychotic drugs with a low side effect profile when medicating Dr. Sell. Dr. Wolfson also intends to avoid sedating Dr. Sell, because his purpose is to allow him to participate meaningfully in his trial. He likewise intends to avoid all other side effects to the maximum extent possible. Thus, the undersigned concludes that the standard required in *Weston, supra*, has been met in the case now at bar.

Based on the above, the undersigned concludes that the government has shown in as strong a manner as possible, that anti-psychotic medications are the only way to render the defendant not dangerous and competent to stand trial on the very serious and violent offenses for which he now stands indicted. There are no other less restrictive means by which this may be accomplished, including other medications, psychotherapy without the use of anti-psychotic medications, and locking down the defendant, all of which have either been attempted or considered. Therefore, the undersigned concludes that Dr. Sell must be involuntarily medicated with anti-psychotic medications.[1]

Based on the above facts and law, the undersigned grants the government's motion for extension of his commitment for a 120-day period of time, because there is a substantial probability that within such period of time, Dr. Sell will attain the capacity to permit the trial to

[1] The defendant cites *United States v. Brandon*, 158 F.3d 947 (6th Cir. 1998) as controlling in this matter. Although the undersigned believes that the government has met the standards required by *Brandon*, it solely involves the legality of the medication of a non-dangerous pretrial detainee unlike the case now at bar.

proceed if medicated. The undersigned further notes that because the defendant has (as is his absolute right) refused to take anti-psychotic medication, and explored all legal means possible to avoid taking the medication, Dr. Sell has not yet been treated with the only treatment which the undersigned has concluded will render him less dangerous and competent. Therefore, based on the above, the government's motion for extension of commitment is granted.

The defendant also alleges that he is being unlawfully held beyond the time authorized by the statute, and that it is unconstitutional to indefinitely commit him for purpose of rendering him competent. In *United States v. Kokoski*, 82 F.3d 411 (4th Cir. 1996), the court ruled that the defendant's right to due process was not violated by an 18-month commitment to obtain his competency. In so holding, the court stated as follows:

> He first argues that § 4241(d) limits the time he may be hospitalized to eight months . . . We reject this argument. We think 'an additional reasonable period of time' means some reasonable but statutorily undefined period of time. *United States v. Ecker*, 30 F.3d 966, 969 (8th Cir. 1994). Here we find that Kokoski's 18-month confinement was reasonable. Every report issued before the Butner staff declared Kokoski competent indicated he was likely to regain competency. The final six months of his confinement were necessary to challenge and clarify Butner's conclusion. In light of the district court's careful adherence to statutory procedures, we believe Kokoski's confinement was reasonable. *See id.* (confinement during seven competency evaluations spanning nearly four years not unreasonable).

82 F.3d 411, 1996 WL 181482. Further, in *United States v. Ecker*, 30 F.3d 966 (8th Cir. 1994), a case involving at least five competency commitments over a three and a half year period of time, the court stated as follows: "The overall determination of ultimate competency to stand trial can extend over a reasonable period." *Id.* at 970. Having considered the background and evidence, the Eighth Circuit held that there "was no clear violation of the statute in ordering each of the several competency evaluations nor an unreasonable overall delay in the proceedings under the circumstances." *Id.* at 970.

Based on the above law, the defendant's request for relief from involuntary commitment should be **denied**.

Therefore,

IT IS HEREBY ORDERED that the government may involuntarily medicate the defendant with anti-psychotic drugs consistent with this memorandum. It is also **ORDERED** that this portion of the court's order shall be stayed for fourteen (14) days to allow the defendant to appeal this portion of the order if he so desires. Any further stay must be granted by a United States District Judge or the United States Court of Appeals.

IT IS FURTHER ORDERED that the government's request for an extension of the defendant's commitment be **granted**, and that his commitment is ordered extended for a 120-day period of time effective as of the date of this order.

IT IS FURTHER ORDERED that defendant's request for relief from involuntary commitment should be **denied**.

IT IS FURTHER ORDERED that this Memorandum and Order supersedes the Interim Order entered by this court on July 28, 2000.

/s/ Terri I. Adelman
UNITED STATES MAGISTRATE JUDGE

Dated this 9th day of August, 2000.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA,	)	
Plaintiff,	)	
vs.	)	No. 4:98CR290-DJS
	)	4:98CR177-DJS
CHARLES THOMAS SELL,	)	
Defendant.	)	(Filed Apr. 4, 2001)

ORDER

Defendant is a pretrial detainee who has been found incompetent to stand trial and who is currently remanded for treatment to the United States Medical Center for Federal Prisoners at Springfield, Missouri ("USMC"). By order dated August 9, 2000, a United States Magistrate Judge granted the government's request for an order authorizing the involuntary administration of anti-psychotic drugs to defendant. On August 18, 2000, the magistrate judge denied defendant's motion seeking reconsideration of the August 9 order, a reopening of the September 29, 1999 hearing in the matter, and the production of certain evidence. The matter is now before the Court on defendant's appeal of the magistrate judge's denial of defendant's motion for reconsideration of the involuntary medication ruling. For reasons explained fully below, the Court here affirms the magistrate judge's ruling that substantive due process does not preclude the forcible administration of anti-psychotic medications to defendant in this case.

Pursuant to 28 U.S.C. § 636(b)(1)(A), defendant's motion concerning involuntary medication was referred to the magistrate judge for his consideration and ruling. Order of 7/30/99 [Doc. #323/#188]. Section § 636(b)(1)(A) provides that a district judge may "reconsider any pretrial matter under this subparagraph (A) where it has been shown that the magistrate's order is clearly erroneous or contrary to law." As indicated above, defendant asks this Court to reconsider the magistrate's denial of the motion to reconsider. In his motion to this Court, defendant characterizes the grounds for reconsideration as follows:

> (1) The Magistrate's findings of fact with regard to the side effects of antipsychotic drugs are squarely refuted by the relevant medical literature and by the testimony adduced at the hearing by both the Government and by Dr. Sell; (2) the Magistrate's finding that Dr. Sell is dangerous is clearly erroneous; (3) the Magistrate improperly based its findings of fact upon the Government's anecdotal evidence and upon communications the Government submitted to the Magistrate ex parte in a post-hearing letter; and (4) the Magistrate's conclusions fail to take into account the effect drugging will have on Dr. Sell's ability to receive a fair trial.

Motion [Doc. #372/#232], p.2 After reviewing the legal principles applicable to the issue of involuntary administration of drugs, the Court will address each of these assertions in turn.

Due Process and the Forcible Administration of Anti-Psychotic Drugs

Certain interests deemed sufficiently fundamental to human liberty are protected by the Due Process Clauses of the Fifth and Fourteenth Amendment. A liberty interest in this protected class cannot constitutionally be impinged by government action unless the infringement is narrowly tailored to serve a compelling state interest. *See, e.g., Reno v. Flores*, 507 U.S. 292, 301-02 (1993). In *Washington v. Harper*, 494 U.S. 210 (1990), the United States Supreme Court held that a prison inmate's interest in resisting involuntary administration of anti-psychotic drugs had Due Process protection. "The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." *Id.* at 220; *see also United States v. Brandon*, 158 F.3d 947, 956-57 (6th Cir. 1998) [applying the strict scrutiny standard to issue of forcible medication of non-dangerous pretrial detainee].

Riggins v. Nevada, 504 U.S. 127 (1992), involved a pretrial detainee:

> Under *Harper*, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness. The Fourteenth Amendment affords at least as much protection to persons the State detains for trial . . . Thus, once Riggins moved to terminate administration of antipsychotic medication, the State became obligated to establish the need for [it] and the medical appropriateness of the drug.

Id. at 135 (internal citations omitted).[1] *Riggins* appears to identify two possibilities for the type of government interest sufficient to override the detainee's protected liberty interest, where medical appropriateness is also shown. These interests are the safety of the detainee and others and the detainee's restoration to competence:

> Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings, Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with anti-psychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others . . . Similarly, the State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means.

Id. at 135 (internal citations omitted).

The proceedings before the magistrate judge were based on the defendant's motion for a judicial hearing on the issue, rather than on a motion from the government which might have more clearly identified the legal and

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[1] The Court respectfully suggests that the Eight Circuit's per curium opinion in *Papantony v. Hedrick*, 215 F.3d 863, 865 (8th Cir. 2000), misspeaks when it characterizes *Riggins* as indicating that a pretrial detainee "likely has no substantive due process right not to be forcibly administered antipsychotic drugs to render him competent for trial."

factual basis on which the involuntary medication was sought. Both dangerousness and the need to restore defendant to competence are touched upon in the record, however, and the magistrate judge's determination that the forcible administration is permissible appears to be based on both rationales. Memorandum and Order of 8/9/00 [Doc. #367/#227], pp. 12-14. The magistrate judge found as follows:

> [T]he undersigned concludes that the government has shown in as strong a manner as possible, that anti-psychotic medications are the only way to render the defendant not dangerous and competent to stand trial on the very serious and violent offenses for which he now stands indicted. There are no other less restrictive means by which this may be accomplished, including other medications, psychotherapy without the use of anti-psychotic medications, and locking down the defendant, all of which have either been attempted or considered. Therefore, the undersigned concludes that Dr. Sell must be involuntarily medicated with anti-psychotic medications.

Id. at 14.[2]

[2] This portion of the ruling belies defendant's contention that the magistrate judge "wholly failed to address the question of whether or not medication is necessary to render Sell competent for trial," a contention that need not be further addressed. Def. Supplemental Memorandum in Support of Motion to Reconsider [Doc. #403/#262], p.5.

Side Effects and Effectiveness of Anti-Psychotic Drugs

Defendant first contends that the magistrate judge's findings of fact on the issue of side effects are erroneous. The magistrate judge's order reviews the evidence concerning three potential side effects: tardive dyskinesia, sedation, and neuroleptic malignant carcinoma. The magistrate judge found that "the serious side effects of the medication will be ameliorated by newer drugs and/or changing of the drugs," and that "the benefits to Dr. Sell of using the medication far outweigh any risks." Memorandum and Order of 8/9/00 [Doc. #367/#227], p.12. Tardive dyskinesia is identified as involuntary body movements. The magistrate judge's order indicates that this effect is not permanent and can be ameliorated by supplemental medications or, as necessary, a change in the anti-psychotic medication. *Id.* at 8. In his motion to this Court, defendant cites to the testimony of a government witness, clinical psychologist Richard DeMier, that the condition is permanent. Motion [Doc. #372/#232], p.9, *citing* Transcript of 9/29/99 Hearing [Doc. #341/#205], p.32.

In his reconsideration ruling of August 18, 2000, the magistrate judge indicated that even if tardive dyskinesia is a permanent effect, he would continue to conclude that "the potential benefit of treatment far outweighs any risk." Memorandum [Doc. #371/#230], p.1. Even under defendant's view of this disputed fact, then, the magistrate judge's conclusion is unaffected. That being the case, any error in his factual finding per se does not require reconsideration by this Court. Furthermore, having reviewed the record upon which the magistrate judge acted, this Court would concur in the conclusion that the medical benefits outweigh the medical risks, giving due weight to the range of seriousness of the various risks, to the prospects for

alleviating certain side effects with supplemental medication, and to the fact that a particular side effect may or may not occur in Dr. Sell.

Defendant also makes generalized arguments concerning the efficacy of anti-psychotic drugs. Having considered all the evidence of record before the magistrate judge, and acknowledging that there exist differences of opinion among practitioners in the field, including the experts relied upon by the parties, the Court cannot conclude that the magistrate judge clearly erred in determining that there is a significant potential medical benefit of treatment with anti-psychotics.[3] As is presumably characteristic in cases of delusions, Dr. Sell does not believe himself to be delusional and, not thinking his delusional beliefs are false, he is not persuaded his delusions require treatment. The Court's analysis begins with a sharply different factual premise, however, namely that Dr. Sell suffers from a serious delusional disorder, which currently significantly impairs and misleads his interpretation of reality and his reasoning. Arguments made on his behalf which neglect to take this into account are

[3] The Court notes that in his appeal to this Court, defendant cites to sources which were not of record before the magistrate judge, some of which could not have been, given their more recent vintage. These included an Indiana Law Review, *Postgraduate Medicine* (2000), and *American Journal of Psychiatry* (2000). The Court here acting as an appellate court of sorts, and given the applicable standard of review, the Court's consideration of this new evidence appears to be inappropriate. In any event, the Court notes that its conclusions concerning risk/benefit analysis and the efficacy or appropriateness of anti-psychotics in Dr. Sell's case would be unaffected by consideration of these sources.

therefore necessarily diminished in their persuasiveness and impact.

The principal basis for the finding of incompetency is the interference of defendant's delusional beliefs with this ability to assist in his defense. These are characterized by his own psychiatrist as "systematized persecutory delusions that he is the victim of a government plot to discredit his allegations about widespread illegal behavior by corrupt individuals to spread HIV and kill innocent civilians throughout the world." 9/28/00 Letter of Dr. Cloninger, attached to Def. Supplemental Memorandum in Support of Motion to Reconsider [Doc. #403/#262]. Defendant believes that this prosecution and the government's position as to his incompetence reflect an effort to cover up his knowledge of the government's culpability in the deaths of David Koresh and his followers in the Branch Dividian compound near Waco, Texas in 1993, knowledge defendant claims to have based on his experiences on Army Reserve duty in Texas at that time. Forensic Psychological Report [Sealed Doc. #304/#169], pp.5-6. Another example of defendant's delusional thinking is described in the testimony of defendant's treating clinician at the magistrate judge's evidentiary hearing:

> [W]hen the U.S. Military initially became involved in the Bosnia conflict, Dr. Sell stated that he expected the U.S. Military to come to our facility to secure his release so that he could go to Bosnia. When he was told that that was not likely to happen, he expressed some delusional beliefs that his presence in Bosnia was absolutely essential to the safety of our troops, and if he weren't permitted to go that would meant that it, to use his words—somebody wanted a lot of American boys dead.

Transcript [Doc. #341/#205], p.11. Risks of unpleasant or even dangerous side effects and the impact of anti-psychotic drugs on Dr. Sell's cognitive processes are counterbalanced by the substantial weight of his current impaired and incompetent state, despite Dr. Sell's protestations to the contrary.

Dangerousness

Defendant argues that the magistrate judge's finding that he is currently a danger to himself or others is clearly erroneous. The magistrate found:

> Because of Sell's specific focus on the nurse, his increasing personalization of the perceived murder plot by the FBI, his personalization of the animosity toward [prison psychologist] DeMier along with the defendant's history of committing an assault on a federal judge, and the fact that the defendant was charged with conspiring to murder an FBI agent and two witnesses in his case, DeMier concluded at the September 29, 1999 hearing that the defendant was an immediate risk to commit violent acts, and was dangerous to himself and to others. DeMier said that because Sell believes that people (including the FBI and DeMier) are out to get him, given Sell's mental condition, Sell is likely to "protect himself" by harming people who have no intention of doing any harm to him. The fact that Sell's delusional beliefs have become more focused makes Sell an immediate risk of violence to himself or others.

Memorandum and Order of 8/9/00 [Doc. #367/#227], p.6. The dangerous nature of the charges against Dr. Sell, involving a murder plot, is self-evident. The government

made little attempt to establish of record before Judge Adelman the particular circumstances of the incident which defendant spat in the face of another magistrate judge, but the incident does not appear to be in dispute. These considerations do not support a finding of current or immediate dangerousness in defendant's present setting, however.

The only evidence of record supporting the asserted personalization of hostility toward Dr. DeMier, defendant's treating clinician, is defendant's telling Dr. DeMier that he should be prepared to testify in Congress concerning his conduct in this case. Transcript, p.10. In testimony concerning a variety of delusional beliefs held by defendant, Dr. DeMier testified that defendant "continues to harbor beliefs that if he were moved to a County Jail, the FBI would have him killed." *Id.* at 11-12. Accepting as true the government's version of the facts concerning defendant's conduct with regard to the nurse, which defendant disputes, the conduct amounted to an inappropriate familiarity and even infatuation with the nurse, but the record does not support the conclusion that the conduct was sufficient to put the nurse in fear of violence from defendant.[4] Even if the trend in defendant's thoughts and feelings is described in Dr. DeMier's testimony and set forth above, and even if, as Dr. DeMier testified, this trend suggests an increased risk of violence, the risk is not shown to be particularly great or imminent.

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[4] This is particularly so because no testimony or other information from the nurse herself was submitted for the record.

The record does not indicate that defendant has posed a danger to himself or others during the period of his institutionalization at the USMC, and the statements and conduct relied upon for finding of dangerousness do not suggest a threat of violence to the staff.[5] Without more, this Court deems it clearly erroneous to conclude that defendant presents a danger to himself or others sufficient to constitute a compelling state interest outweighing his interest in refusing anti-psychotic medication. The Court's conclusion in this regard is based both on the relative weight of the facts evidenced in the record and what the Court regards as the appropriate legal standard for finding of dangerousness for the present purpose. The Court here makes explicit its view that the standard of dangerousness pertinent to the determination now before it concerns defendant's dangerousness *at this time* to himself and to those around him *in his institutional context*. The determination here made would not necessarily bear on any finding concerning defendant's dangerousness to himself, the public, or any other particular persons if released from an institutional setting.

The claim of dangerousness may also be a post hoc justification. Notice of the institutional medication hearing was given to defendant as early as April 28, 1999, just two weeks after he was found incompetent to stand trial and ordered hospitalized for treatment. *See* "Notice of Medication

[5] Defendant was transferred to a locked-down cell as a disciplinary measure after he allegedly disregarded the nurse's directive to leave the nurse's station, but has since been returned to an open ward. *See* Defendant's Update to Supplemental Memorandum [Doc. #405/#264] and Defendant's Second Update to Supplemental Memorandum [Doc. #408/#267].

Hearing and Advisement of Rights" form included in Addendum Exh. A to Def. Motion Regarding Involuntary Psychiatric Treatment and Medication [Doc. #322/#187]. The April 28, 1999 notice provided to defendant stated that the proposed treatment was "Antipsychotic medication" and that the reason for such treatment was to "Restore competency to stand trial." *Id.* Dangerousness in his prison setting was not a basis for the administrative decision to forcibly medicate defendant. *See* "Involuntary Medication Report" included in Addendum Exh. A to Def. Motion Regarding Involuntary Psychiatric Treatment and Medication [Doc. #322/#187]. Instead, the administrative determination was based on the conclusion that anti-psychotic drugs were medically necessary as treatment for defendant's delusional and possibly schizophrenic state.

Anecdotal Evidence and Ex Parte Materials

Defendant next contends that the officials of the USMC improperly communicated with the magistrate judge by letter on March 20, 2000, and that the ex parte materials should not have been considered by the magistrate judge to support a finding of dangerousness. This communication consists of a letter from the warden and a "Brief Hospitalization Summary and Request for Extension of Commitment" signed by Dr. DeMier, and appears to be intended as a 120-day report on defendant's hospitalization. Particularly in the context of these proceedings, where the issues concerning anti-psychotic medication are so highly contested, the letter and report should have been served by the USMC on counsel for both parties. In any event, given this Court's conclusion on the issue of dangerousness sufficient to outweigh defendant's liberty interest, the issue need not be further addressed.

The remainder of this point on appeal consists of argument with the sufficiency of the "anecdotal evidence" supporting the opinions of the government's witnesses, treating psychologist Dr. DeMier and consulting psychiatrist Dr. Wolfson, concerning the safety and efficacy of anti-psychotic medications. The Court has earlier expressed its view that the magistrate judge's findings on these issues were adequately supported by the record, and defendant's additional arguments do not disturb that view. To the extent that defendant argues he should have an opportunity to adduce expert testimony challenging DeMier's and Wolfson's conclusions, the argument is entirely unavailing. Defendant has had every opportunity to offer such testimony, at or in the substantial period of time since the evidentiary hearing held on September 29, 1999.

Defendant's Trial Rights

Finally, defendant argues that the forcible administration of anti-psychotic medication will adversely affect his ability to obtain a fair trial by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom and/or by rendering him unable or unwilling to assist counsel. If defendant's medication renders him unable or unwilling to assist counsel, an unfair trial will not occur. A showing that he is unable to assist properly in his defense would result in a continued finding that defendant is not be competent to stand trial.

That the effects of medication might prejudice the defense at trial is a serious issue, but not one which can preclude forcible medication based on the necessarily generalized manner in which the argument must be

presented at this time. The issue is, in effect, premature. Until defendant is treated with anti-psychotic medication, its effects on his demeanor cannot reasonably be assessed. In its appellate role, the Court is unpersuaded that the magistrate judge's conclusion in favor of forcible medication is the result of legal or factual error on the issue of medication's impact on defendant's trial rights.

In its capacity as the trial court in this case, the Court here states that if medication is administered and the defense presents argument and evidence concerning its adverse effect on Dr. Sell's ability to defend himself, the Court will give the issue careful consideration. The Court commends to the parties the careful treatment of the trial rights issue by Judge Sullivan of the United States District Court of the District of Columbia in his recent decision in the *Weston* case, on the basis of a substantially more complete record. *United States v. Weston*, ___ F. Supp.2d ___, 2001 WL 286406 at *15-*19, slip op. at pp.44-57 (D.D.C. March 6, 2001). As Judge Sullivan states:

> The Court will reassess, upon request, its determination regarding the prejudice to Weston's fair trial rights resulting from medication when testimony about the actual, not hypothetical, impact of the medication is available. The Court is confident that any such review will not come too late to prevent impairment of Weston's rights. However, since Weston's reaction to the medication is, at this point, unknown, by proceeding the medicate him, the government risks the possibility of forfeiting its right to bring Weston to trial. Nevertheless, the Court is reasonably confident, based on the persuasive expert testimony, that any prejudice that

might arise would occur with ample time for the Court to revisit these issues.

If Weston is medicated and his competency is restored, the Court is willing to take whatever reasonable measures are necessary to ensure that his rights are protected. This may include informing the jurors that Weston is being administered mind-altering medication, that his behavior in their presence is conditioned on drugs being administered to him at the request of the government, and allowing experts and others to testify regarding Weston's unmedicated condition, the effects of the medication on Weston, and the necessity of medication to render Weston competent to stand trial.

Id. at *19, slip op. at 56-57.

Alternative Basis for Affirmance

The Court reverses the finding below that defendant's dangerousness is a sufficient basis to override his protected liberty interest in refusing anti-psychotic medication at this time. The Court may, however, affirm the magistrate judge on any ground supported by the record, and the Court concludes there is such an alternate ground in this case. *See Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 621 (8th Cir. 1998). As earlier noted, the magistrate judge concluded that the forcible administration of anti-psychotic medication was supported by the government's strong showing that such drugs "are the only way to render the defendant not dangerous *and competent to stand trial on the very serious and violent offenses for which he now stands indicted*" and that "[t]here are no other less restrictive means by which this may be accomplished." Memorandum

and Order of 8/9/00 [Doc. #367/#227], p. 14 (emphasis added). Under *Riggins*, the government's inability to "obtain an adjudication of [defendant's] guilt or innocence by using less intrusive means" may be a compelling interest which overrides defendant's liberty interest against taking the drugs.

This Court agrees with the magistrate judge that this is such a case. The interest in adjudication of the charges is less compelling in cases involving lesser offenses. Here, in addition to 63 counts involving mail fraud, Medicaid fraud and money laundering, defendant is charged with conspiring to kill, and attempting to kill, a witness and an FBI agent. The seriousness of these charges contributes greatly to the compelling strength of the government's interest in adjudicating defendant's guilt. *See United States v. Weston*, ___ F.Supp.2d ___, 2001 WL 286406 at *14, slip op. at pp. 42-43 (D.D.C. March 6, 2001).

In summary, the Court concludes that the record supports three findings: (1) that anti-psychotic drugs are medically appropriate for defendant, (2) that they represent the only viable hope of rendering defendant competent to stand trial, and (3) that the administration of such drugs appears necessary to serve the government's compelling interest in obtaining an adjudication of defendant's guild or innocence of numerous and serious charges. These findings yield the conclusion that defendant's substantive due process rights do not preclude the involuntary administration of anti-psychotic medication.

Accordingly,

IT IS HEREBY ORDERED that defendant's motion to reconsider the magistrate judge's August 21, 2000 order [Doc. #372/#232] is denied.

IT IS FURTHER ORDERED that defendant's motion to reconsider and request for discharge from custody or for a hearing pursuant to 18 U.S.C. § 4246(e) [Doc. #407/#266] is denied.

IT IS FURTHER ORDERED that the magistrate judge's order permitting the involuntary administration of anti-psychotic medication to defendant Charles Sell is stayed for fourteen (14) days to permit defendant to take an appeal from this ruling. Any further stay must be granted by the United States Court of Appeals.

Dated this 4th day of April, 2001.

/s/ Donald J. Stohr
United States District
Judge

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282 F.3d 560

United States Court of Appeals,
Eighth Circuit.

UNITED STATES of America, Appellee,

v.

Charles Thomas SELL, Appellant,

Association of American Physicians & Surgeons, Inc. Amicus on Behalf of Appellant.

No. 01-1862.

Submitted: Oct. 15, 2001.

Filed: March 7, 2002.

Rehearing and Rehearing En Banc
Denied May 7, 2002.*

Lee T. Lawless, St. Louis, Missouri, argued, for appellant.

Dorothy L. McMurtry, Assistant U.S. Attorney, St. Louis, Missouri, argued (Raymond W. Gruender and Howard J. Marcus, on the brief), for appellee.

Before BOWMAN, HEANEY and BYE, Circuit Judges.

HEANEY, Circuit Judge.

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* Judges Loken, Murphy, Bye, and Riley would grant the petition for rehearing en banc. Judge McMillian took no part in the consideration of this case.

Appellant Dr. Charles Sell, D.D.S. is charged with health care fraud, attempted murder, conspiracy, and solicitation to commit violence. In this appeal, Sell challenges the district court's[1] determination that he may be involuntarily medicated with antipsychotic drugs for the sole purpose of rendering him competent for trial. We affirm.

I. Background

On May 16, 1997, Sell was charged in a federal criminal complaint with making false representations in connection with payments for health care services in violation of 18 U.S.C. § 1035(a)(2). The government alleged that Sell and his wife submitted false claims to Medicaid and private insurance companies for dental services not provided, including false documentation and bogus x-rays in support of these claims. On May 20, 1997, the government filed a motion for psychiatric examination of Sell to determine his competence to stand trial.[2] On May 20, 1997, a magistrate judge ordered that Sell be sent to the U.S. Medical Center for Federal Prisoners at Springfield, Missouri ("Springfield") for an evaluation. On July 15, 1997, after receiving a psychiatric evaluation from Springfield, the district court held that Sell was competent to stand trial. The report, which was accepted without objection, stated that Sell was currently competent to stand trial but that there was a possibility that he would

[1] The Honorable Donald J. Stohr, United States District Court for the Eastern District of Missouri.

[2] Sell has a history of mental illness.

develop a psychotic episode in the future. On July 30, 1997, an indictment was returned against Sell and his wife, charging them with fifty-six counts of mail fraud, six counts of medicaid fraud, and one count of money-laundering.

In August 1997, Sell was released on bond. On January 22, 1998, the government filed a bond revocation petition alleging that Sell had violated the conditions of his release by attempting to intimidate a witness. A warrant was issued for Sell's arrest and he was brought before a magistrate judge for an initial appearance. Sell's behavior at this appearance was out of control. He screamed, shouted, and used racial epithets. Nonetheless, the judge tried to proceed, but when she advised Sell of his rights, he leaned towards her and spit directly in her face.

On January 26, 1998, a bond revocation hearing was held, and shortly thereafter, the court ordered that Sell's bond be revoked and that he be detained. At this hearing, the court received evidence that Sell's mental condition was deteriorating. Sell was not sleeping at night because he expected the FBI to barge into his house. A psychiatrist reported that Sell soon could become a danger to himself and others.

On April 23, 1998, Sell was charged in a second indictment with conspiring and attempting to kill a witness and an FBI agent. The government contends that Sell and his wife asked a hit man to plot the murder of a former employee at his dental office who planned to testify against him on the fraud charges. The government also alleges that Sell plotted to kill the African-American FBI agent who had arrested him. The two indictments were joined.

During the next several months, the trial date was continued on a number of occasions at the request of both parties. On February 9, 1999, Sell's counsel filed a motion asking this court to hold a hearing to determine Sell's competency. The government filed a separate motion to have a government psychologist examine Sell. Both Sell's psychologist and the government psychologist diagnosed Sell with delusional disorder, persecutory type.[3]

On April 14, 1999, the district court held a hearing on Sell's competency. Upon consideration of the evidence, the court found that Sell was suffering from a mental disease or defect rendering him incompetent to assist properly in his defense, and thus incompetent to stand trial. The court ordered that Sell be hospitalized at Springfield for a reasonable period of time not to exceed four months to determine whether there was a substantial probability that Sell would attain the capacity to stand trial.

At Springfield, Sell was under the care of two clinicians, Dr. DeMier, the clinical psychiatrist, and Dr. Wolfson, the consulting psychiatrist. Both Dr. DeMier and Dr. Wolfson determined that Sell was in need of antipsychotic medication.[4] On June 9, 1999, an administrative hearing

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[3] Delusional disorder is characterized by the presence of one or more non-bizarre delusions that persist for at least one month. *Diagnostic and Statistical Manual of Mental Disorders IV* at 296. The delusions are generally plausible ideas that can conceivably occur in real life. *Id.* The persecutory subtype of delusional disorder is characterized by a person's belief that he is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long term goals. *Id.* at 298.

[4] Justice Kennedy described antipsychotic medications in his concurring opinion in *Riggins v. Nevada:*

(Continued on following page)

First introduced in the 1950's, antipsychotic drugs ... have wide acceptance in the psychiatric community as an effective treatment for psychotic thought disorders. *See American Psychiatric Press Textbook of Psychiatry* 770-774 (J. Talbott, R. Hales, & S. Yodofsky eds. 1988 (*Textbook of Psychiatry*)); Brief for American Psychiatric Association as Amicus Curiae 6-7. The medications restore normal thought processes by clearing hallucinations and delusions. *Textbook of Psychiatry* at 744.

Riggins v. Nevada, 504 U.S. 127, 141, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) (Kennedy, J., concurring). In *Washington v. Harper,* the Supreme Court discussed the side effects associated with antipsychotic medications:

> The purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes. (Citation omitted). While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects. One such side effect identified by the trial court is acute dystonia, a severe involuntary spasm of the upper body, tongue, throat, or eyes. The trial court found that it may be treated and reversed within a few minutes through use of the medication Cogentin. Other side effects include akathesia (motor restlessness, often characterized by an inability to sit still); neuroleptic malignant syndrome (a relatively rare condition which can lead to death from cardiac dysfunction); and tardive dyskinesia, perhaps the most discussed side effect of antipsychotic drugs. See Finding of Fact 9, App. to Pet. for Cert. B-7; Brief for American Psychological Association as Amicus Curiae 6-9. Tardive dyskinesia is a neurological disorder, irreversible in some cases, that is characterized by involuntary, uncontrollable movements of various muscles, especially around the face. See *Mills,* 457 U.S., at 293, n. 1, 102 S.Ct., at 2445, n. 1. The State, respondent, and amici sharply disagree about the frequency with which tardive dyskinesia occurs, its severity, and the medical profession's ability to treat, arrest, or reverse the condition. A fair reading of the evidence, however, suggests that the proportion of patients treated with antipsychotic drugs who exhibit the symptoms of tardive dyskinesia ranges from 10% to 25%. According to the American Psychiatric Association, studies of the condition indicate that

(Continued on following page)

was held before a medical hearing officer. Dr. DeMier and Dr. Wolfson testified in favor of using antipsychotic medication in the treatment of Sell, and testified that it was the only way he could be restored to competency. Sell proffered the affidavit of his psychiatrist, Dr. Cloninger, who asserted that he did not think Sell would respond well to medication. Cloninger Aff. ¶¶ 8, 17. Sell also called a number of witnesses and testified that he did not want to take antipsychotic medication and have his chemistry altered. The medical hearing officer concluded that antipsychotic medication was the treatment of choice. This finding was based on the fact that his delusional thinking could make him dangerous and that no other drug could treat his delusional symptoms. Dr. Sell filed an administrative appeal that was denied. The Medical Center delayed the administration of the medication to give Sell the opportunity to seek review by the district court.

On September 29, 1999, a United States Magistrate Judge conducted a full judicial hearing. At that hearing, the Government called two witnesses, Dr. DeMier and Dr. Wolfson. They testified that Sell was in need of antipsychotic medication, that his condition would continue to deteriorate without it, that his behavior could be dangerous, and that antipsychotic medication was likely to restore him to competency. On August 9, 2000, the magistrate entered

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60% of tardive dyskinesia is mild or minimal in effect, and about 10% may be characterized as severe. Brief for American Psychiatric Association et al. as Amici Curiae 14-16, and n. 12; see also Brief for American Psychological Association as Amicus Curiae 8.

Washington v. Harper, 494 U.S. 210, 229-30, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990).

an order finding that Sell posed a danger to himself and others. *United States v. Sell,* No. 4:98CR177, (E.D.Mo. Aug. 9, 2000) (order granting government's motion to involuntarily medicate defendant). Based on this finding, the magistrate authorized the government to forcibly medicate Sell with antipsychotic medication.

In April 2001, the district court reversed the magistrate's finding that Sell posed a danger to himself and others, noting that the evidence in the record was insufficient to support such a finding. Despite this reversal, the district court affirmed the magistrate's order, holding that the Government's interest in restoring Sell to competency so that he can stand trial was alone sufficient to warrant forcible medication.

Sell appeals this decision and asks this court to decide whether the district court erred in holding that he could be forcibly injected with antipsychotic drugs for the sole purpose of restoring his competency to stand trial. Sell also asks us to examine whether: (1) the district court applied the correct standard of review; (2) whether the district court properly considered his Sixth Amendment right to a fair trial, and (3) whether the government has proven by clear and convincing evidence that the medication is medically appropriate and that the medication has a reasonable probability of restoring his competency. The Government argues that the district court did not err on these grounds. It further argues that the district court's finding that Sell was not dangerous was erroneous and that Sell's dangerousness provides an alternate ground for affirmance in this case.

II. Discussion

A. Sell's Dangerousness to Himself and Others.

First, we consider the government's claim that the district court erred in overturning the magistrate's determination that Sell is dangerous. We review the district court's determination of questions of fact under the clearly erroneous standard. *See United States v. Kissinger,* 986 F.2d 1244, 1246 (8th Cir.1993). The government argues that the district court did not give adequate weight to Sell's *potential* to be a danger to himself or others. The district court noted, however, that Sell's inappropriate behavior at Springfield amounted at most to an "inappropriate familiarity and even infatuation" with a nurse. Upon review, we agree that the evidence does not support a finding that Sell posed a danger to himself or others at the Medical Center. The district court properly reversed the magistrate's finding.

B. Forcible Administration of Antipsychotic Drugs to Restore Competency

Next, we consider the question of whether the district court erred in holding that a pretrial detainee may be forcibly injected with antipsychotic medication for the sole purpose of rendering him competent to stand trial. This is an issue of first impression for this court. *Cf. Papantony v. Hedrick,* 215 F.3d 863, 865 (8th Cir.2000) (holding that in the context of a *Bivens* action, there is no clearly established right of a pre-trial detainee not to be forcibly administered antipsychotic drugs for the sole purpose of rendering him competent for trial). In *Washington v. Harper,* the Supreme Court recognized that individuals possess "a significant liberty interest in avoiding unwanted

administration of antipsychotic drugs." 494 U.S. 210, 221, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990); *cf. United States v. Weston,* 255 F.3d 873, 876 (D.C.Cir.2001) (citations omitted) ("The due process liberty interest in avoiding unwanted antipsychotic medication may be 'significant,' but it is not absolute."). In *Harper,* a convicted prison inmate claimed that the State of Washington violated his due process rights by administering antipsychotic drugs against his will. 494 U.S. at 217, 110 S.Ct. 1028. The Court acknowledged that Harper had a liberty interest in avoiding unwanted medication but held that the "Due Process Clause permits the state to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if [the inmate] is dangerous to himself or others and the treatment is in [the inmate's] medical interest." *Id.* at 211, 110 S.Ct. 1028.

In *Riggins v. Nevada,* the Court applied its *Harper* analysis to the issue of whether a pre-trial detainee may be forcibly injected with antipsychotic medication for the purpose of rendering him competent for trial. 504 U.S. 127, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992). In *Riggins,* a pre-trial detainee was forcibly administered the antipsychotic drug Mellaril after a Nevada district court denied the detainee's pre-trial motion to terminate the medication with a one-page order that gave no indication as to the court's rationale. *See id.* at 130-31, 112 S.Ct. 1810. A jury convicted Riggins,[5] and he appealed, arguing that the forced administration of Mellaril denied him the ability to assist in his own defense and prejudicially affected his

[5] At trial, Riggins unsuccessfully presented an insanity defense and was convicted of murder and sentenced to death.

attitude, appearance and demeanor at trial. *See id.* at 131, 112 S.Ct. 1810. Riggins further argued that the prejudice was not justified because the state did not demonstrate a need to administer the drug, nor did it explore alternative treatments. The Supreme Court agreed, and held that Riggins's Fourteenth Amendment rights had been violated because the Nevada court did not acknowledge the detainee's liberty interest in freedom from unwanted medication, make any findings on the need for forced medication, and make findings on reasonable alternatives to antipsychotic medication. *See id.* at 136-37, 112 S.Ct. 1810. The Court also noted that forcible administration of antipsychotic drugs may have interfered with Riggins's Sixth Amendment right to a fair trial. *See id.* The Court, therefore, reversed and remanded the case.

The Supreme Court did not have the opportunity to determine when involuntary medication could be used on a pre-trial detainee because the Nevada court offered the accused almost no protection against involuntary medication. The Supreme Court did note, however, that:

> Under *Harper,* forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness. The Fourteenth Amendment guarantees at least as much protection to persons the state detains for trial. (Citation omitted).
>
> . . . Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the district court had found, that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others. (Citation omitted). Similarly, the state might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means.

Id. at 135, 112 S.Ct. 1810.

Based on this language, we conclude that subject to the limitations outlined below, the government may forcibly administer antipsychotic medication for the sole purpose of rendering a pre-trial detainee competent to stand trial without violating the accused's due process rights.

C. The Standard of Review for Forcible Administration of Antipsychotic Drugs.

We now consider Sell's claim that the district court employed the wrong standard of review to determine whether forced administration of medication is appropriate in this case. Sell encourages us to adopt strict scrutiny, but the Supreme Court declined to adopt such a standard in *Riggins. See Riggins,* 504 U.S. at 136, 112 S.Ct. 1810.[6] Based on the Supreme Court's decisions in *Riggins* and *Harper,* and the decisions of our sister courts,[7] we hold that

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[6] The court stated: "We have no occasion to finally prescribe such substantive standards . . . since the District Court allowed administration of Mellaril to continue without making any findings about reasonable alternatives." *Riggins,* 504 U.S. at 136, 112 S.Ct. 1810.

[7] Other courts have come to contradictory conclusions on what substantive standards are necessary to satisfy a pretrial detainee's due process rights. The Sixth Circuit held that courts must apply the strict scrutiny standard when the state wishes to forcibly medicate a non-dangerous pre-trial detainee. *See United States v. Brandon,* 158 F.3d

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the government must meet the following test in order for the government to forcibly medicate an individual. First, the government must present an essential state interest that outweighs the individual's interest in remaining free from medication. *See Riggins,* 504 U.S. at 135, 112 S.Ct.

947, 960 (6th Cir.1998). The D.C. Circuit interpreted *Riggins* to require "heightened scrutiny" that takes into consideration the severity of infringement that antipsychotic drugs impose on an individual's liberty interest, the need to find an essential state policy that provides an overriding justification for forced medication, and a requirement to consider less intrusive alternatives. *See United States v. Weston,* 255 F.3d 873, 880 (D.C.Cir.2001). Similarly, the Southern District of California refused to adopt a strict scrutiny standard. Rather, it stated that the government must meet the following standard:

> First, the government must demonstrate that "administration of anti-psychotic drugs is necessary to accomplish an essential state policy." (Citation omitted). Second, the government must show that "there is a sound medical basis for treatment with anti-psychotic medication." (Citation omitted). In making this showing, the government may provide "medical testimony regarding [Defendant's] mental illness and its symptoms as well as the effects that anti-psychotic medication will have, both beneficial and harmful, on [Defendant's] physical and mental health." Third, and most importantly, the government must establish "that there is no significant risk that the medication will alter in any material way the defendant's capacity or willingness to react to testimony at trial or assist counsel." (Citation omitted). [T]he government must establish these elements by clear and convincing evidence.

United States v. Sanchez-Hurtado, 90 F.Supp.2d 1049, 1055 (S.D.Cal.1999). Like our sister courts, we believe that we must apply some sort of heightened standard of review, but unlike the Sixth Circuit, we do not adopt the strict scrutiny standard. *See e.g. Weston,* 255 F.3d at 888 (noting that the Supreme Court denied adopting a strict scrutiny test in *Riggins* but also appeared not to apply a reasonableness test or its various analogues: arbitrary and capricious, rational basis or exercise of professional judgment).

1810 (noting that the government must prove an overriding state interest). Second, the government must prove that there is no less intrusive way of fulfilling its essential interest. *See id.* Third, the government must prove by clear and convincing evidence that the medication is medically appropriate. *See id.* Medication is medically appropriate if: (1) it is likely to render the patient competent, *see Weston,* 255 F.3d at 876; (2) the likelihood and gravity of side effects do not overwhelm its benefits, *see id.;* and (3) it is in the best medical interests of the patient. *See Harper,* 494 U.S. at 227, 110 S.Ct. 1028 (noting that the court should consider the petitioner's medical interest). The district court did not explicitly apply this test, so we review the district court in light of the standards we have set forth.

The first question, therefore, is whether the district court erred by holding that the government's interest in bringing Sell to trial is sufficient to outweigh Sell's interest in refusing medication. This is a mixed question of law and fact, so we review the district court's finding de novo. *See Boysiewick v. Schriro,* 179 F.3d 616, 619 (8th Cir. 1999). To make this determination, we must weigh the government's interest in rendering Sell competent against Sell's interest in refusing unwanted medication.

The government has an essential interest in bringing a defendant to trial. *See Illinois v. Allen,* 397 U.S. 337, 347, 90 S.Ct. 1057, 25 L.Ed.2d 353 (1970) (Brennan, J., concurring) ("Constitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and a prerequisite to social justice and peace."). Not all charges, however, are sufficient to justify forcible medication of a defendant; rather, the charges must be serious. *See United States v. Brandon,* 158 F.3d 947, 961 (6th Cir. 1998). Here,

the sixty-two charges of fraud and the single charge of money-laundering are serious, a fact not denied by the defendant.[8] Despite Sell's significant liberty interest in refusing antipsychotic medication, in view of the seriousness of the charges, we believe that the government's interest in restoring his competency so that he may be brought to trial is paramount.[9]

The second part of our analysis is whether the district court erred in finding that there were no less intrusive means by which the government may achieve its essential interest. *See Riggins,* 504 U.S. at 135, 112 S.Ct. 1810 (noting that the government must prove that there is no less intrusive means). The government may not constitutionally bring an incompetent defendant to trial, *see Pate v. Robinson,* 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed.2d 815 (1966), so the only way the government may try Sell is by restoring his competency. Both Dr. Wolfson and Dr. DeMier testified that antipsychotic medication is the most effective treatment for delusional disorder and that it is the only way Sell could be restored to competency. *See* Transcript of Evidentiary Hr'g, Sept. 29, 1999 at 21, 75-78. Even Dr. Cloninger, who submitted an affidavit on behalf

[8] Although Sell is also charged with conspiring to murder an FBI officer and a witness, we base our reasoning solely on the seriousness of the fraud charges. It is possible that Sell's threats after his first indictment were a manifestation of his delusional disorder and we decline to make a determination about whether those charges suffice to involuntarily medicate him.

[9] We note that the government's interest in preserving a scheme of ordered liberty can only be achieved if a defendant is competent at trial. If the medication does not render Sell competent, his trial cannot proceed. *See infra* Part II.D.

of Sell and stated that antipsychotic drugs are not a proven treatment, did not suggest any alternative means of restoring competency. *See generally* Cloninger Aff. Based on this evidence, we believe that the district court correctly concluded that there were no less intrusive means.

Third, we must determine whether the evidence supports the district court's conclusion that antipsychotic medication is medically appropriate for Sell's treatment. We review the district court's findings of fact under the clearly erroneous standard. *See Love v. M.D. Reed,* 216 F.3d 682, 687 (8th Cir. 2000). Whether a proposed action is medically appropriate depends on the judgment of medical professionals. *See Harper,* 494 U.S. at 231, 233-34, 110 S.Ct. 1028. At the hearing before the Magistrate Judge, the government presented testimony from Dr. DeMier and Dr. Wolfson. Dr. DeMier, Sell's treating psychologist, testified that antipsychotic medication is the only treatment that has been shown to be effective in treating delusional disorder and it is the only treatment that could restore Sell to competency. He also stated that he has treated two patients suffering from delusional disorder with antipsychotic medication. Of the two, one was restored to clinical competency; the other patient improved, but did not regain competency.[10] Dr. DeMier also stated that antipsychotic medications have "potentially significant side effects, but there's also potentially, very significant recovery from symptoms."

[10] The patient who was successfully treated was given Haldol, a typical antipsychotic drug. The patient who was not restored to competency received Olanzapine, an atypical antipsychotic drug.

Dr. Wolfson, the staff psychiatrist who works as a consultant on Sell's case, also recommended that Sell be treated with antipsychotic drugs. Dr. Wolfson has treated seven patients with delusional disorder but only four for the purpose of restoring competency.[11] Dr. Wolfson reported that all seven benefitted clinically from antipsychotic medication and of the four who were treated for restoration of competency, three regained competency. Dr. Wolfson testified that the medical literature indicated that patients with delusional disorder respond less to medication than patients with other illnesses, but he stated that he doubts the accuracy of that conclusion and noted that the literature shows favorable results in many cases.[12] Dr. Wolfson admitted that there are both harmful and unpleasant side effects to antipsychotic drugs; these include sedation, neuroleptic malignant syndrome, which is rare but fatal,[13] and tardive dyskinesia and/or dystonic reaction, which causes a person to have involuntary movements of various parts of the body. Dr. Wolfson also stated, however, that the existence and/or degree of side effects could be controlled by changes in the doses and type of medication

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[11] He treated one of the patients twice. This patient was restored to competency, relapsed, then restored a second time.

[12] Dr. Wolfson explained that:

> First, the delusions stop expanding. . . . It's even conceivable that some delusional material may regress. . . . [O]ur first goal [is] to diminish the impact on . . . actions and . . . judgment of the illness. Second, [is] to minimize the expansion of the delusional system. . . . [I]t's typically been my experience [that this is] accomplished with other patients.

Transcript of Evidentiary Hr'g, Sept. 29, 1999 at 137.

[13] Dr. Wolfson testified that the incidence of this side-effect is one in ten thousand cases.

being used. He testified that the new generation of atypical antipsychotic drugs, such as Pimozide, have more benign side effects than the older typical antipsychotic drugs, such as Haldol. Dr. Wolfson admitted, however, that the atypical drugs can only be administered orally, and therefore cannot be used to forcibly drug uncooperative patients.

To combat this testimony, Sell presented the affidavit of Dr. Cloninger. Dr. Cloninger stated that "there is no evidence that [antipsychotic medications] are beneficial for patients with Delusional Disorder." Cloninger Aff. at 8. Dr. Cloninger admitted that antipsychotic drugs are often beneficial in treating schizophrenia but maintained that they do not provide the same benefit in the treatment of delusional disorder. Dr. Cloninger attached to his affidavit an excerpt from the American Psychiatric Press Textbook of Psychiatry. That text notes that there is a disagreement between experts on the effectiveness of treating delusional disorders with antipsychotic medication, but it also states that the medication may be useful, particularly for accompanying anxiety, agitation, and psychosis. Donald W. Black et al., *Schizophrenia, Schizophreniform Disorder, and Delusional (Paranoid) Disorders,* in *Textbook of Psychiatry* (John A. Talbott et al. eds.) 1988. Dr. Cloninger was not able to recommend a less intrusive alternative to restore Sell to competency; rather, he suggested that treatment be limited to basic support and voluntary symptomatic treatment, and that such treatment also include access to exercise and reading material. *See* Cloninger Aff. ¶¶ 18-19.

In addition, Sell also presented the court with a report from the Federal Bureau of Prisons Institutional Metropolitan Correctional Center ("MCC") in which Dr. Daniel Greenstein, the forensic psychologist at MCC, stated that

delusional disorders do not typically respond to medication or psychotherapy.

Based on the totality of this evidence, Sell argues that the district court was clearly erroneous in finding that antipsychotic medication was medically appropriate. He contends that the district court erred by basing its finding, in part, on testimony that atypical antipsychotic medications have more benign side effects, because atypical drugs can only be administered orally, thus they cannot be given involuntarily. Sell also argues that the government did not prove that the medication has a reasonable probability of restoring competency. Finally, Sell argues that the court erred in finding medical appropriateness when the government failed to disclose which medication it would use.[14] Sell posits that without knowing which drugs would be administered, he was incapable of making anything more than a generalized argument. *See United States v. Sell*, No. 4:98CR177 at 7 (April 4, 2001) (upholding Magistrate's order allowing the involuntarily medication of Sell and stating that Sell's arguments against medication were generalized).

We disagree with these assertions. We acknowledge that there is a difference of opinion on the efficacy of using antipsychotic drugs to treat delusional disorder, but we do not believe that the district court committed clear error in finding that the government proved medical appropriateness by clear and convincing evidence. First, the government

[14] Dr. Wolfson stated that he did not want to be pinned down to a single drug because he hoped to leave part of the choice up to Sell. He recommended that the drugs Quetiapine or Olanzapine be used.

presented evidence that the medication can reasonably be expected to minimize Sell's delusions and render him competent for trial. Dr. DeMier has a 50% success rate and Dr. Wolfson has a 75% success rate in restoring competency to patients with delusional disorders. Moreover, the medication improved the condition of all the patients they treated, whether or not they were restored to competency. Dr. Wolfson testified about how the medication works, stating that the medication should reduce the impact of the delusion on Sell's thought process. Although we cannot say with 100% certainty whether Sell will regain competency with his treatment, the district court did not clearly err in finding a sufficient likelihood that antipsychotic medication will restore Sell's competence.

Second, the government proved that the side-effects produced by the medication could be minimized through careful treatment and changing medications and dosages. Although Dr. Wolfson did not name a specific medication, he did name the two he would most likely use. Therefore, we reject Sell's contention that he was not given the opportunity to make specific objections to specific drugs. Furthermore, we reject Sell's argument that the court erred in basing its opinion in part on the availability of atypical antipsychotic drugs which can only be administered orally. The availability of the atypical medications was not determinative to the district court's findings, and the evidence supports the conclusion that the doctors treating Sell will be able to reduce the incidence of unpleasant and harmful side-effects produced by typical antipsychotic medication as well.

Finally, the district court appropriately considered Sell's medical interest. The court noted that Sell's delusions interfere with his ability to make sound judgments

about his life and his treatment, and that his disorder currently impairs and misleads his interpretation of reality and his reasoning. The government presented evidence that antipsychotic medication is commonly used to help reduce delusions and their impact on an individual's life, and the court found that these benefits outweighed the risks associated with antipsychotic drugs.

The district court did not err in applying the wrong standard of review. As required, the court found that the government has an essential interest in adjudicating the serious charges against Sell. The court found that involuntary medication is the only way for the government to achieve its interest in fairly trying Sell and found that the medication is medically appropriate for him. The government proved these elements by clear and convincing evidence. Therefore, we find no reversible error in the standard of review employed by the district court.

We note, however, that this is a limited holding. We do not believe this standard will be met in all circumstances in which the government wishes to restore competence. Furthermore, we note that an entirely different case is presented when the government wishes to medicate a prisoner in order to render him competent for execution. *See, e.g., Singleton v. Norris,* 267 F.3d 859 (8th Cir. 2001), *vacated and reh'g en banc granted* (Dec. 5, 2001). Therefore, our holding must be read narrowly.

D. Sell's Sixth Amendment Rights

Finally, we consider whether the district court properly considered Sell's Sixth Amendment right to a fair trial when it ordered the forcible medication. The district court held that Sell's Sixth Amendment claim was premature

because the effects of the medication on his competency to assist counsel and on his demeanor could properly be considered after medication. We note that before forcibly medicating an accused, there must be evidence that he will be able to participate in a fair trial. *See Brandon,* 158 F.3d at 960. That burden was met in this case. First, the magistrate found that the evidence indicated that Sell would be able to participate meaningfully in his trial while he is under the influence of the medication. *See United States v. Sell,* 4:98CR177 at 13 (E.D.Mo. Aug. 9, 2000). Also, the magistrate found that the medication would allow him to communicate with his counsel in a rational manner. *See id.* The magistrate further noted that Dr. Wolfson intends to use drugs with a low side-effect profile, to change drugs and dosages based on the side-effects Sell experiences, and above all, to avoid sedation. *See id.* The district court affirmed these findings. *See generally United States v. Sell,* 4:98CR177 at 5-9 (E.D.Mo. Apr. 4, 2001).

We find that the medical evidence presented indicated a reasonable probability that Sell will fairly be able to participate in his trial. As a result, we believe that the effects of the medication on Sell's competency and demeanor may properly be considered once the medication is administered. The district court noted its willingness to reexamine Sell's Sixth Amendment claim after the medication regimen has begun. *See id.* at 15. The evidence offered, that the drugs should not interfere with Sell's right to a fair trial, as well as post-medication procedures that ensure he will not be tried unfairly, are sufficient to protect Sell. There is no reversible error.

III. Conclusion

Having found no reversible errors, we affirm the district court's determination that Sell may be involuntarily medicated for the purpose of rendering him competent to stand trial.

BYE, Circuit Judge, dissenting.

Unlike the majority, I would apply the strict scrutiny standard of review for the reasons enunciated by the Sixth Circuit in *United States v. Brandon,* 158 F.3d 947, 956-61 (6th Cir. 1998). But even under the majority's three-part test, the charges against Dr. Sell are not sufficiently serious to forcibly inject him with antipsychotic drugs on the chance it will make him competent to stand trial. I therefore respectfully dissent.

The first part of the majority's test requires the government to demonstrate an essential interest that outweighs his interest in remaining free from medication. *Ante* at 567. The majority perfunctorily concludes the government's interest in prosecuting the defendant for sixty-two counts of fraud and one count of money laundering qualifies as an essential interest that trumps Dr. Sell's significant liberty interest in refusing antipsychotic medication. I strongly disagree.

While the government possesses an interest in bringing a defendant to trial, *ante* at 568, I do not believe every charge is sufficient to justify forcible medication of a defendant. *See Riggins v. Nevada,* 504 U.S. 127, 135, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) (stating the government *might* be able to medicate a defendant involuntarily if "it could not obtain an adjudication of [his] guilt or innocence by using less intrusive means") (emphasis added). It is helpful to compare two recent decisions confronting this precise issue. In *United States v. Weston,* 255 F.3d 873 (D.C.Cir.2001), the Court of Appeals for the District of Columbia recognized the government's interest in adjudicating those who violate the law. In that case, Russell Weston entered the Capitol building and shot three police officers, killing two of them. A grand jury indicted Weston on two counts of *murder,* and one count of *attempted murder* of a federal law officer, in addition to three counts of *using a firearm in a crime of violence.* *Weston* explained that "[t]he government's interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business." 255 F.3d at 881. *Weston* also noted "[t]he statutory sentences for the crimes Weston is accused of committing – *life in prison and death* – reflect the intensity of the government's interest in bringing those suspected of such crimes to trial." *Id.* (emphasis added).

Weston typifies the case where the government's interest is paramount because the charges include the most serious crimes known to man. Few cases involve crimes as serious as those in *Weston,* however. In *Brandon,* the Sixth Circuit noted the government's reduced interest in trying a defendant accused of lesser crimes. 158 F.3d at 947. Ralph Brandon was charged with sending a threatening communication through the mail. The Sixth Circuit stated "[w]e find it difficult to imagine . . . that the government's interest in prosecuting the charge of sending a threatening letter through the mail could be considered a compelling justification to forcibly medicate Brandon." *Id.* at 961; *cf. Bee v. Greaves,* 744 F.2d 1387, 1395 (10th

Cir.1984) (questioning whether the state's interest in trying suspects could ever outweigh a criminal defendant's interest in avoiding forcible medication with antipsychotic drugs). *Brandon* also noted the maximum penalty the defendant faced for sending a threatening communication – five years imprisonment. 158 F.3d at 961.

Weston and *Brandon* teach us that the forcible administration of antipsychotic medication may be warranted when the government seeks to prosecute incontestably serious crimes, but not when it seeks to prosecute crimes less so. Cases involving crimes of intermediate severity may present vexing questions, but Dr. Sell's case poses no such challenge. The crimes with which he has been charged are comparable to those in *Brandon* and thoroughly distinct from those in *Weston*. Dr. Sell is charged with making false representations in connection with the payment of health care services, 18 U.S.C. § 1035(a)(2), and money laundering, 18 U.S.C. § 1957(a). The maximum penalty for these charges is five and ten years imprisonment, respectively. He cannot be put to death nor imprisoned for life if convicted of these crimes, as was the case in *Weston*. He is charged with crimes which are far less serious than the violent, heinous and deadly crimes with which Weston was charged. Indeed, they are nonviolent and purely economic. There is no identifiable victim for these types of crimes; rather, only society's interest is harmed.

The majority deems the charges serious in part because of the number of counts Dr. Sell faces (63). At first blush, the sixty-two counts of fraud and the single count of money laundering might appear to make the charges seem more serious, but the sheer number is an inaccurate yardstick for measuring the severity of his alleged offenses. He

will be sentenced under the United States Sentencing Guidelines, which direct his sentence to be determined by the total dollar value of the fraud, *not* the number of counts. *See* U.S. Sentencing Guidelines Manual (U.S.S.G.) ch. 3 pt. D & §§ 5G1.2, 2B1.1, 2S1.1 (2001). An overly generous estimation of Dr. Sell's alleged illegal activity would place the value of his fraud within the range of $400,000 to $1,000,000. Applying this estimate, his base offense level would be 20 and (assuming he has no prior criminal history) his sentencing range would be 33-41 months. *See* U.S.S.G. § 2B1.1. This sentencing range demonstrates the charges against him are not serious enough to justify forcible medication. *Ante* at 568 ("Not all charges, however, are sufficient to justify forcible medication of a defendant; rather, the charges must be serious"). In any event – setting aside the Guideline estimations altogether – Dr. Sell's potential sentence is far more proportional to the maximum five year sentence in *Brandon* than to the maximum life-in-prison and death sentences in *Weston*.

The majority states Dr. Sell does not deny the severity of the fraud and money laundering charges. *Ante* at 568. This representation is wrenched from its context, however. While he does not deny the severity of these charges in the abstract, he certainly does not concede they are serious enough to warrant forced medication. In fact, Dr. Sell devotes most of his efforts to defending and minimizing the charges of conspiring to murder an FBI agent and witness, not to discussing the fraud and money laundering charges.

More telling still, neither the government nor the district court believe the fraud and money laundering charges *alone* support the forcible administration of

medication. The government all but dismisses these counts when arguing about the severity of the charges against him. The government focuses its attention almost entirely on the charges related to the conspiracy to murder the FBI agent and witness. Neither in its brief, nor during oral argument, has the government claimed the fraud and money laundering charges by themselves are serious enough to warrant forced medication. Likewise, the district court acknowledged the conspiracy to commit murder charges tipped the balance in its conclusion that Dr. Sell's alleged offenses were serious enough to warrant the forcible administration of antipsychotic drugs.

Although the majority properly omits the charges of conspiracy to commit murder from its analysis, *ante* at 568 n. 8, the majority inexplicably turns a blind eye to the apparent agreement of all parties that the fraud and money laundering charges alone are insufficiently serious to warrant forcible medication. This course of action is questioned.

This is not meant to suggest the crimes with which Dr. Sell has been charged should not be prosecuted. They will and should be. However, this defendant should not be forced to take antipsychotic drugs in order to be prosecuted for them. The government's interest in forcibly medicating an accused murderer may be essential, but its interest in forcibly medicating an accused thief is not. In my view, these charges are not serious enough to warrant the forced medication of the defendant, who, we must not forget, is a non-dangerous pre-trial detainee cloaked with the presumption of innocence. As a result, the government

has failed to satisfy the first part of the majority's three-part test.

* * *

The government is not without recourse upon a finding that the charges against Dr. Sell are insufficiently serious to warrant forcible medication. He will not be set free. A civil commitment is in order for him until he becomes competent, or voluntarily agrees to take medication. *See Riggins,* 504 U.S. at 145 (Kennedy, J., concurring) (stating that if the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment). The government asserts that its interest in punishing crime will be diminished by the option of civil commitment. It is true Dr. Sell's criminality will not be adjudicated as the civil commitment unfurls. However, the government's interest in forcing him to stand trial on charges that may result in such limited punishment does not outweigh his substantial rights under the First, Fifth and Sixth Amendments. *See Brandon,* 158 F.3d at 956-61 (enumerating an individual's rights in refusing antipsychotic medication).

I respectfully dissent.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 01-1862

United States of America,

Appellee,

vs.

Charles Thomas Sell,

Appellant

Association of American Physicians & Surgeons, Inc., et al.,

Amici on Behalf of Appellant.

Order Denying Petition for Rehearing and for Rehearing En Banc

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

Judges Loken, Murphy, Bye, and Riley would grant the petition for rehearing en banc.

Judge McMillian took no part in the consideration of this case.

(5128-010199)

May 7, 2002

Order Entered at the Direction of the Court:

/s/ Michael E. Gans

Clerk, U.S. Court of Appeals, Eighth Circuit

(*CORRECTED* ORDER LIST: 537 U.S.)

MONDAY, NOVEMBER 4, 2002

CERTIORARI GRANTED

02-5664 SELL, CHARLES T. V. UNITED STATES

The motion of petitioner for leave to proceed *in forma pauperis* is granted. The motion of Law Office of Julie Ruiz-Sierra for leave to file a brief as *amicus curiae* is denied. The petition for a writ of certiorari is granted limited to the following question: Whether the Court of Appeals erred in rejecting petitioner's argument that allowing the government to administer antipsychotic medication against his will solely to render him competent to stand trial for non-violent offenses would violate his rights under the First, Fifth, and Sixth Amendments.

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(6)

No. 02-5664

In The
Supreme Court of the United States

CHARLES THOMAS SELL, D.D.S.,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

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QUESTION PRESENTED

Whether the Court of Appeals erred in rejecting petitioner's argument that allowing the government to administer antipsychotic medication against his will solely to render him competent to stand trial for non-violent offenses would violate his rights under the First, Fifth, and Sixth Amendments?

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The Court of Appeals' opinion is reported at *United States v. Sell*, 282 F.3d 560 (8th Cir. 2002) and is reproduced in the joint appendix hereto at pages 356 through 382. The magistrate judge's opinion, which was not published, is reproduced in the appendix hereto at pages 320 through 338. The District Court's opinion is not reported and is reproduced in the appendix hereto at pages 339 through 355. The Court of Appeals' denial of the petition for rehearing is reproduced on page 383 of the joint appendix.

JURISDICTIONAL STATEMENT

A divided panel of the Court of Appeals entered its judgment on March 7, 2002. On May 7, 2002, by a vote of 5-4, the Court of Appeals denied the petition for rehearing and the petition for rehearing *en banc*. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Constitutional Provisions.

U.S. CONST. amend. I:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

U.S. CONST. amend. V:

> No person shall be . . . deprived of life, liberty, or property, without due process of law. . . .

U.S. CONST. amend. VI:

> In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial . . . and to have the Assistance of Counsel for his defence.

Statutory Provisions.

18 U.S.C. § 4241: Determination of mental competency to stand trial

> (a) Motion to determine competency of defendant. – At any time after the commencement of a prosecution for an offense and prior to the sentencing of the defendant, the defendant or the attorney for the Government may file a motion for a hearing to determine the mental competency of the defendant. The court shall grant the motion, or shall order such a hearing on its own motion, if there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense.
>
> (b) Psychiatric or psychological examination and report. – Prior to the date of the hearing, the court may order that a psychiatric or psychological examination of the defendant be conducted, and that a psychiatric or psychological report be filed with the court, pursuant to the provisions of section 4247 (b) and (c).

> (c) Hearing. – The hearing shall be conducted pursuant to the provisions of section 4247(d).
>
> (d) Determination and disposition. – If . . . the court finds by a preponderance of the evidence that the defendant is presently suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense, the court shall commit the defendant to the custody of the Attorney General. The Attorney General shall hospitalize the defendant for treatment in a suitable facility –
>
> (1) for such a reasonable period of time, not to exceed four months, as is necessary to determine whether there is a substantial probability that in the foreseeable future he will attain the capacity to permit the trial to proceed; and
>
> (2) for an additional reasonable period of time until –
>
> (A) his mental condition is so improved that trial may proceed, if the court finds that there is a substantial probability that within such additional period of time he will attain the capacity to permit the trial to proceed; or
>
> (B) the pending charges against him are disposed of according to law;
>
> whichever is earlier.
>
> If, at the end of the time period specified, it is determined that the defendant's mental condition has not so improved as to permit the trial to

proceed, the defendant is subject to the provisions of section 4246.

18 U.S.C. § 4246: Hospitalization of a person due for release but suffering from mental disease or defect

(a) Institution of proceeding. – If the director of a facility in which a person is hospitalized certifies that a person in the custody of the Bureau of Prisons whose sentence is about to expire, or who has been committed to the custody of the Attorney General pursuant to section 4241(d), or against whom all criminal charges have been dismissed solely for reasons related to the mental condition of the person, is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another, and that suitable arrangements for State custody and care of the person are not available, he shall transmit the certificate to the clerk of the court for the district in which the person is confined. The clerk shall send a copy of the certificate to the person, and to the attorney for the Government, and, if the person was committed pursuant to section 4241(d), to the clerk of the court that ordered the commitment. The court shall order a hearing to determine whether the person is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another. A certificate filed under this subsection shall stay the release of the person pending completion of procedures contained in this section.

(b) Psychiatric or psychological examination and report. – Prior to the date of the hearing, the

court may order that a psychiatric or psychological examination of the defendant be conducted, and that a psychiatric or psychological report be filed with the court, pursuant to the provisions of section 4247(b) and (c).

(c) Hearing. – The hearing shall be conducted pursuant to the provisions of section 4247(d).

(d) Determination and disposition. – If, after the hearing, the court finds by clear and convincing evidence that the person is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another, the court shall commit the person to the custody of the Attorney General. The Attorney General shall release the person to the appropriate official of the State in which the person is domiciled or was tried if such State will assume responsibility for his custody, care, and treatment. The Attorney General shall make all reasonable efforts to cause such a State to assume such responsibility. If, notwithstanding such efforts, neither such State will assume such responsibility, the Attorney General shall hospitalize the person for treatment in a suitable facility, until –

(1) such a State will assume such responsibility; or

(2) the person's mental condition is such that his release, or his conditional release under a prescribed regimen of medical, psychiatric, or psychological care or treatment would not create a substantial risk of bodily injury to another person or serious damage to property of another;

whichever is earlier. The Attorney General shall continue periodically to exert all reasonable efforts to cause such a State to assume such responsibility for the person's custody, care, and treatment.

STATEMENT OF THE CASE

I. Dr. Charles Thomas Sell.

Dr. Charles Thomas Sell ("Dr. Sell") is a fifty-three year old dentist who is currently confined in the United States Medical Center for Federal Prisoners (the "Center") in Springfield, Missouri. (Record on Appeal ("Record") 1108, 1136; Appendix ("App.") 339). Dr. Sell is a non-dangerous, pre-trial detainee, who has been confined either at the Center or other facilities for almost five years. (Record 559, 730-46, 1001-09; App. 349-50). Dr. Sell is accused of insurance fraud, but has been adjudged incompetent to stand trial.[1] (App. 339, 359). Dr. Sell's pretrial detention is already longer than the period of time that he would have served if convicted of the fraud charges.[2] Dr. Sell has been diagnosed as suffering from delusional disorder, persecutory type. (App. 30). The government seeks to administer antipsychotic medication

[1] While there are other charges pending, the charges relating to insurance fraud were the sole basis for the Court of Appeals' decision regarding involuntary medication. (282 F.3d at 568 n.8; App. 369).

[2] Using the 1998 version of the Sentencing Guidelines, his total offense level on the fraud charges should be 23 with a criminal history category of I, giving a range of 46-57 months of imprisonment. U.S. SENTENCING GUIDELINES MANUAL, ch. 5, Part A, at 310 (1998). (*See also Sell*, 282 F.3d at 573 (Bye, dissenting); App. 379-80).

to Dr. Sell against his will solely to make him competent to stand trial. (App. 357).

Dr. Sell is an intelligent, educated individual. He graduated from Saint Louis University High School and Saint Louis University, both Jesuit institutions. (Record 1108). He completed his undergraduate degree in 1972 with a major in biology/chemistry and was awarded a doctorate in dental surgery from the University of Missouri-Kansas City in 1976. (Record 1108). After graduation, he obtained a dental license from the Missouri Dental Board (Record 1136) and opened a private dental practice in Des Peres, Missouri. (Record 1108). In private practice, he performed general dentistry, endodontics, oral surgery, periodontics, pedodontics, prosthodontics, and geriatric dentistry. (Record 1099). For several years, Dr. Sell's dental practice thrived in a relatively affluent area of St. Louis County, Missouri.

In 1977, Dr. Sell married his first wife, Deborah. (Record 1091). They had three children together. (Record 1091). In 1983, Deborah left Dr. Sell, which caused him extreme emotional difficulty. (1999 Forensic Psychological Report ("1999 FPR") at 3 (filed under seal)). In 1984, Dr. Sell fell in love with and later married his second wife, Mary, and the couple conceived Dr. Sell's fourth child, Robert L. Sell, in 1987. (Record 1087).

In 1982, Dr. Sell joined the United States Army Dental Reserve. (Record 1130). He received officer training at Fort Sam Houston in Texas. After training, the Army promoted Dr. Sell to the rank of Captain. (1999 FPR at 3). He excelled at his assigned tasks, and effective January 11, 1990, the army promoted him to the rank of Major. (Record 1085).

During the 1980s and continuing into the 1990s, Dr. Sell occasionally suffered from recurrences of the emotional difficulties that had surfaced following his divorce from Deborah, and he periodically sought treatment from psychiatrists or psychologists. (1997 Forensic Report ("1997 FR") at 3 (filed under seal)). He received psychotherapy, and, at times, his clinician treated him with antidepressants. (*See, e.g.*, 1997 FR at 4). Once, in the early 1980s, he was briefly treated with an antipsychotic drug, Haldol. (Record 589). Dr. Sell found the side effects of the drug to be intolerable. (Record 617 (Dr. James K. Wolfson testifying that Dr. Sell had suffered, at minimum, dystonic reaction from Haldol and that Dr. Sell had complained that Haldol gave him "all types of problems")). In fact, Dr. Sell has likened taking antipsychotic drugs to a lobotomy, and he is opposed to antipsychotic medication. (Record 509). He expressed this opposition in his appeal of the Center's administrative involuntary medication decision: "I have a God given right not to have [my brain] altered by the government's antipsychotic, psychotropic medication." (Record 511).

II. Criminal Proceedings.

On May 16, 1997, the government filed a complaint alleging that Dr. Sell had committed insurance fraud by, among other things, submitting doctored invoices to insurers for the purpose of obtaining payment for services not covered by the policies. (App. 1, 7). On May 20, 1997, the government moved for a psychiatric examination to assess Dr. Sell's competency to stand trial. (Record 3-5). A magistrate judge ordered that Dr. Sell be transferred to the Center for a psychological assessment (Record 8-10), and, on June 24, 1997, further ordered that a competency

hearing be held. (Record 11-12). The Center conducted a psychological assessment, and, on June 20, 1997, provided the magistrate judge with a Forensic Report setting forth the Center's findings. (1997 FR at 1). The conclusions in the Forensic Report were tentative because Dr. Sell refused to discuss his case history with the evaluator. (1997 FR at 2). The evaluator, a neuropsychologist, provided the following assessment to the court:

> It must be noted that the undersigned evaluator provides this opinion with less confidence than customary. . . . [I]t is the undersigned evaluator's opinion that Charles Thomas Sell does not currently suffer from a mental disease or defect, and that he is competent to the extent he is able to understand the nature and consequences of the proceedings against him and assist properly in his defense.
>
> ***PROGNOSIS***
>
> Currently, Dr. Sell evidences no obvious signs of psychosis. It is likely his mental status should stay consistent in the near future, but there is a possibility he could develop a psychotic episode depending on the nature of any past mental illnesses. It is impossible for the undersigned evaluator to be more specific given the lack of information. He does have a [sic] paranoid personality characteristics which are pervasive and will color interactions between Dr. Sell, counsel, and the Court.

(1997 FR at 8). At a hearing on July 15, 1997, the court considered the Forensic Report and determined that Dr. Sell was competent to stand trial. (Record 13-15). On July 30, 1997, Dr. Sell was indicted for Medicaid and insurance fraud. (App. 7).

On October 14, 1998, counsel for Dr. Sell filed a notice of intent to introduce evidence of mental disease or defect (Record 285-86), and, in response, the government requested an additional psychiatric examination (Record 287-88, 303-07), which Dr. Sell opposed. (Record 293-302). On November 25, 1998, the magistrate judge denied the government's request for a second competency determination, but ordered a second psychological assessment based upon Dr. Sell's interposition of the diminished capacity defense. (Record 308-17).

Counsel for Dr. Sell then enlisted the services of a private psychiatrist, Dr. C. Robert Cloninger, to conduct an independent assessment of Dr. Sell's competency. (Record 326-27). Dr. Cloninger is the Wallace Renard Professor of Psychiatry at Washington University, a Professor of Genetics & Psychology at Washington University, and the Director of the Center for Psychobiology of Personality with an extensive educational background in the psychology of delusional disorder and personal experience in treating patients with the disorder. (Record 417-58 (Dr. Cloninger's curriculum vitae)). He has over two hundred publications to his credit, and he was head of the Department of Psychiatry at Washington University from 1989 to 1994. (Record 419).

Dr. Cloninger examined Dr. Sell, who cooperated in the examination. (Record 326-27). Dr. Cloninger reviewed Dr. Sell's medical records, spoke personally with Dr. Sell's prior treating physicians, and concluded that Dr. Sell suffered from delusional disorder, persecutory type and that Dr. Sell was not competent to stand trial. (Record 326-27). Counsel for Dr. Sell moved for a second competency hearing. (Record 326-27). On February 16, 1999, the government moved for a competency assessment pursuant

to 18 U.S.C. § 4241(b) (Record 330-32), which was granted by the magistrate judge on February 22, 1999. (Record 337-39). The Center again assessed Dr. Sell and provided the court with a second Forensic Psychology Report. In the 1999 Forensic Psychology Report, the Center agreed with Dr. Cloninger's diagnosis of delusional disorder, persecutory type, finding that Dr. Sell's persecutory delusions were specifically directed to the United States government and its agents. (1999 FPR at 7-8). The Center further found that Dr. Sell was not greatly impaired, was not schizophrenic, did not suffer from bizarre delusions, and did not display prominent hallucinations. (1999 FPR at 8).

Based upon these findings, the District Court found Dr. Sell incompetent to stand trial on April 14, 1999 because Dr. Sell "suffer[ed] from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him, and to assist properly in his defense." (Record 341). Pursuant to 18 U.S.C. § 4241(d), the court committed Dr. Sell to the custody of the United States Attorney General for a reasonable period of time "not to exceed four months." The Department of Justice then committed Dr. Sell to the custody of the Center, where he has been confined now for over three and one-half years, which is in addition to the almost one and one-half years Dr. Sell has spent in various county jails awaiting trial.

III. Delusional Disorder.

As discussed above, both Dr. Cloninger and the Center staff have diagnosed Dr. Sell as suffering from delusional disorder, persecutory type. (App. 30; 1999 FPR at 7-8). The

Diagnostic and Statistical Manual of Mental Disorders IV ("DSM-IV") describes the diagnostic features of delusional disorders as follows:

> The essential feature of Delusional Disorder is the presence of one or more nonbizarre delusions that persist for at least 1 month (Criterion A). A diagnosis of Delusional Disorder is not given if the individual has ever had a symptom presentation that met Criterion A for Schizophrenia (Criterion B). Auditory or visual hallucinations, if present, are not prominent. Tactile or olfactory hallucinations may be present (and prominent) if they are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions or infestation, or the perception that one emits a foul odor from a body orifice associated with delusions of reference.) *Apart from the direct impact of the delusions, psychosocial functioning is not markedly impaired, and behavior is neither obviously odd or bizarre* (Criterion C). If mood episodes occur concurrently with the delusion, the total duration of these mood episodes is relatively brief compared to the total duration of the delusional periods (Criterion D). The delusions are not due to the direct physiological effects of a substance (e.g., cocaine) or a general medical condition (e.g., Alzheimer's disease, systematic lupus erythmatosus) (Criterion E).

(Record 638-39, 766 (emphasis added)). Persons suffering from delusional disorder may be unimpaired in their occupational and social roles, and any delusions are generally plausible ideas "that can conceivably occur in real life." (Record 767). In fact, prior to and at the time of

his arrest, Dr. Sell was functioning perfectly well in society. (Record 640).

Delusional disorder may be subcategorized based upon the predominant delusional theme. Dr. Sell has been diagnosed as suffering from the persecutory subtype of delusional disorder, which DSM-IV defines as follows:

> **Persecutory Type.** This subtype applies when the central theme of the delusion involves the person's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals. Small slights may be exaggerated and become the focus of a delusional system. The focus of the delusions is often on some injustice that must be remedied by legal action ("querulous paranoia"), and the affected person may engage in repeated attempts to obtain satisfaction by appeal to the courts and other government agencies. Individuals with persecutory delusions are often resentful and angry and may resort to violence against those they believe are hurting them.

(Record 768).

A prominent feature of Dr. Sell's disorder is his belief that the FBI is plotting to discredit and/or kill him. (Record 807, 809; 1999 FPR at 6). This delusion involves Dr. Sell's belief that his Army Reserve assignment to Fort Sam Houston, Texas in April, 1993 was made in anticipation of an incendiary assault on the Branch-Davidian, Waco, Texas, compound in which government agents might die and require dental record identification. (Record 376-78). Dr. Sell believes that he watched the incident on a closed circuit transmission different from that which was generally broadcast, and which showed the intentional burning

of the compound by government agents. (Record 376-77). He told his psychiatrist about his perception of the events at Waco and believes this information was forwarded to the FBI. (Record 377-78). According to Dr. Sell, in an effort to conceal the "truth" about Waco, the FBI arranged for Dr. Sell to be charged with insurance fraud to discredit him and may seek to kill him. (Record 378).

The indicated treatment for delusional disorder is still the subject of debate. (App. 345 (United Stated District Court Judge Donald J. Stohr acknowledging the debate among experts)). For example, one of the texts upon which the government clinicians have relied and which the government clinicians identified as being authoritative in the field (Record 584) describes the treatment indicated for persons suffering from delusional disorder:

> The goals of treatment are to establish the diagnosis, to decide on appropriate interventions, and to manage complications. Fundamental to the success of those goals is an effective and therapeutic doctor-patient relationship. Establishing that is far from simple. The patients do not complain about psychiatric symptoms and often enter treatment against their will. Even the psychiatrist may be brought into the delusional nets.
>
> . . . .
>
> Delusional disorder is a psychotic disorder by definition, and the natural presumption has been that the condition would respond to antipsychotic medication. Because controlled studies are lacking and the disorder is uncommon, the results required to support this practice have not yet been obtained.

(Record 994-95). Despite their endorsement of this text during the involuntary medication hearing, both government witnesses testified that antipsychotic medication was effective in treating delusional disorder. (*See, e.g.*, Record 583).

IV. The Involuntary Medication Proceedings.

In 1999, the Center sought to forcibly drug Dr. Sell to attempt to restore him to competency. (Record 348). On June 9, 1999, the Center conducted an administrative hearing pursuant to 28 C.F.R. § 549.43 after which the Center authorized itself to forcibly drug Dr. Sell with antipsychotic medication to restore Dr. Sell to competency. In connection with these proceedings, Dr. C.D. Glazzard, the Center's reviewing psychologist at the time, prepared an Involuntary Medication Report ("IMR"). (App. 141-51). In the IMR, Dr. Glazzard summarized Dr. Sell's statement in opposition to the medication: "I do not want to take medicine. I do not want my chemistry altered. My brain is working well." (App. 142).

At the hearing, the government did not claim that Dr. Sell was dangerous. The IMR contained a separate section allowing the examiner to check off the specific findings upon which the involuntary medication determination had been made. (App. 144-45). The options included the opportunity to make determinations of dangerousness and competency to stand trial. (App. 144-45). The dangerousness entry was marked "No." (App. 144). The competency to stand trial entry was marked "Yes." (App. 145). The Warden reviewed and affirmed the administrative decision. (App. 152-57). He, too, did not find Dr. Sell to pose a danger to himself or others.

Dr. Sell then sought judicial review of the administrative decision, which the magistrate judge granted on August 20, 1999. (Record 357, 517-19). At the judicial hearing on September 29, 1999, the government claimed for the first time (and without notice to Dr. Sell) that Dr. Sell should be forcibly drugged because Dr. Sell posed a danger to himself or others. (Record 523; App. 172-73). The basis for the government's dangerousness theory was, among other things, Dr. Sell's alleged acts of familiarity with a nurse (Nurse Goldberg) at the Center – acts such as addressing the nurse by her first name. (App. 168-70, 263-64). The magistrate judge heard the testimony of a government psychologist and psychiatrist, who opined that this behavior evidenced dangerousness. (App. 172-73). At the hearing, despite its expressed conclusion that Dr. Sell needed medication, the government refused to identify the antipsychotic drugs or dosages it planned to give Dr. Sell. (App. 189).

Almost a year later, on August 9, 2000, the United States magistrate judge entered an order finding that Dr. Sell posed a danger to himself and others. (Record 816). Based upon this finding, the magistrate judge authorized the government to forcibly medicate Dr. Sell with antipsychotic drugs. (Record 820). Dr. Sell sought review of the magistrate judge's Order with the District Court. (Record 846-64).

On April 4, 2001, the District Court reversed the magistrate judge's finding that Dr. Sell posed a danger to himself and others. (App. 347-50). The District Court held that the record evidence was insufficient to support such a finding and that the magistrate judge's decision was, therefore, clearly erroneous:

> The record does not indicate that defendant has posed a danger to himself or others during the period of his institutionalization at the [Center], and the statements and conduct relied upon for a finding of dangerousness do not suggest a threat of violence to the staff. Without more, this Court deems it clearly erroneous to conclude that defendant presents a danger to himself or others sufficient to constitute a compelling state interest outweighing his interest in refusing antipsychotic medication. . . .
>
> The claim of dangerousness may also be a post hoc justification. . . . Dangerousness in his prison setting was not a basis for the administrative decision to forcibly medicate defendant.

(App. 349-50 (internal citations and quotations omitted)).

Despite finding the magistrate judge's decision clearly erroneous, the District Court affirmed the magistrate judge's Order respecting forced medication on a different ground. (App. 354). The District Court held that the government's interest in restoring Dr. Sell to competency was alone sufficient to warrant forcible medication:

> This Court agrees with the magistrate judge that this is such a case [warranting involuntary medication for the sole purpose of restoring competency]. The interest in adjudication of the charges is less compelling in cases involving lesser offenses. . . . The seriousness of [the charges against Dr. Sell] contributes greatly to the compelling strength of the government's interest in adjudicating defendant's guilt.

(App. 354). On this ground, the District Court affirmed the magistrate judge's involuntary medication order.

An appeal was taken to the United States Court of Appeals for the Eighth Circuit. On March 7, 2002, a divided panel affirmed the District Court's order over the vigorous dissent of the Honorable Circuit Judge Kermit Bye. While the panel found that Dr. Sell did not pose a danger to himself or others and considered only the non-violent charges, the panel found that Dr. Sell could be involuntarily medicated solely for the purpose of attempting to render him competent to stand trial. On May 7, 2002, in a five-to-four vote, the Eighth Circuit denied Dr. Sell's petition for rehearing *en banc*.

V. Antipsychotic Drugs.

Antipsychotic medications are potent, mind-altering drugs with the potential for severe, irreversible, and even deadly side effects. (*See* App. 185-86 (Richart DeMier ("DeMier") acknowledging that the side effects are "significant")). Antipsychotic drugs do not cure mental illnesses; they simply suppress the symptoms. (App. 136-37 (Dr. Wolfson testifying that drugs stop the expansion of delusions, but do not resolve the underlying illness)). The efficacy of antipsychotic drugs in cases of delusional disorder is uncertain. (App. 345 (Judge Stohr acknowledging the disagreement among experts); App. 215 (DeMier testifying that "in many cases" delusional symptoms abate)).

The potential difficulties inherent in Dr. Sell's efforts to resist forced drugging are complicated by the fact that the government will not disclose the precise drugs or dosage it intends to administer. (App. 185 (DeMier testifying that he "would not recommend one agent over another" because he does not "have the expertise"); App. 238 (Dr.

Wolfson testifying that he prefers "not to get pinned down" to a single drug)). Moreover, the efficacy of the medication varies according to a given case history. (App. 165, 216 (stating antipsychotic medication less effective when treatment delayed for significant period of time)).

At the September 29, 1999 involuntary medication hearing, the government called two witnesses: DeMier, the Center psychologist treating Dr. Sell, and Dr. Wolfson, the Center psychiatrist who consulted for medication purposes. (App. 159). DeMier testified that, although he is not licensed to prescribe medication, he has treated two patients suffering from delusional disorder with antipsychotic medication. (App. 174). Of the two, one was restored to clinical competency. (App. 175). The successful antipsychotic medication was Haldol, a typical antipsychotic drug. (App. 175). The unsuccessful drug was Olanzapine, an atypical antipsychotic drug. (App. 175-76). Dr. Wolfson testified that he had treated four patients with delusional disorder in an institutional setting with antipsychotic medication. (App. 240). One of these patients was apparently restored to competency, relapsed, then restored a second time. (App. 241).

At the hearing, the government witnesses testified that as a result of being medicated, Dr. Sell may develop tardive dyskinesia, a permanent condition which may cause Dr. Sell to have abnormal motor movements. (App. 186). Dr. Sell may also develop neurolectic malignant syndrome, a potentially fatal condition that can cause a person to appear awake, but be listless and dazed. (App. 187). Dr. Wolfson also testified that the new generation of atypical antipsychotic drugs, such as Pimozide, have a more benign side effect profile than the older typical antipsychotic drugs, such as Haldol. (App. 237-38). The

magistrate judge and District Court relied upon this testimony in finding involuntary medication to be appropriate in Dr. Sell's case. (App. 333-34, 354). However, Dr. Wolfson also testified that atypical antipsychotic drugs can only be administered orally, and therefore cannot be used to forcibly drug uncooperative patients like Dr. Sell. (App. 238).

In addition, Dr. Sell presented evidence that directly contradicted the government's testimony regarding the efficacy of antipsychotic medication. Dr. Cloninger testified by affidavit that, in his personal experience, as well as the literature he deemed authoritative, antipsychotic medication is not effective for the treatment of delusional disorder. (App. 30-33). Because delusional disorder is rare, few psychiatrists have experience treating it. (App. 30, ¶4). However, based upon his personal experience and a review of the literature, Dr. Cloninger concluded that "there is no evidence that neuroleptics [meaning, antipsychotic medication] are beneficial for patients with delusional disorder." (App. 31, ¶8). Further, Dr. Cloninger submitted a report by Stein Opjordsmoen and Nils Rettorstol that reached the same conclusion. (App. 31, ¶6; 132-38). He also submitted an authoritative text that indicates antipsychotic medication may be useful for anxiety, agitation, and psychosis, but will not alone be effective in eliminating delusional disorder. (App. 30, ¶5; 92-106).

Dr. Sell also presented the court with a report from the Federal Bureau of Prisons, Metropolitan Correctional Center ("MCC Chicago"), in which Dr. Daniel Greenstein, the forensic psychologist at MCC Chicago, stated that "[d]elusional disorder does not typically respond to pharmacological intervention or psychotherapy." (App. 216-17). In its Order, the District Court specifically acknowledged the conflicting views among the experts. (App. 345 ("there

exist differences of opinion among practitioners in the field, including the experts relied upon by the parties")). Despite the conflict and uncertainty, the District Court ordered that Dr. Sell be forcibly medicated.

VI. Dr. Sell's Confinement at the Center.

Dr. Sell's efforts to resist involuntary medication have been complicated by his continued confinement. The District Court's original April 14, 1999 Order authorized the government to confine Dr. Sell for four months. (Record 341-42). This four-month period expired on August 14, 1999. On August 29, 1999, the District Court entered an order authorizing the government to continue Dr. Sell's confinement for an additional period of time – 120 days. (Record 517-19). The 120-day extension expired on December 27, 1999. Despite the expiration of the District Court's orders, the government continued to confine Dr. Sell. When Dr. Sell moved for relief from this detention, the District Court ordered Dr. Sell confined for an additional 120 days and, to date, has continued to order subsequent 120-day periods of confinement with occasional lapses during which time Dr. Sell has been confined in the Center without an order authorizing his detention. (Record 800; *see also* Record 1001-09).

Dr. Sell's efforts to resist involuntary medication have been further complicated by the nature of his confinement at the Center, which ironically has comported with Dr. Sell's delusions related to persecution by the government. For example, Dr. Sell has spent a significant amount of time isolated in Section 10E, the Center's lockdown unit. In the lockdown unit, detainees are isolated for twenty-three hours a day behind steel doors, notwithstanding that

isolation is contraindicated for persons afflicted with delusional disorder. (App. 180). In addition, Dr. Sell has not received any psychological treatment for his delusional disorder during his confinement at the Center. (App. 177, 188).

Dr. Sell also has been subjected to physical abuse while detained at the Center. For example, Dr. Sell has complained to the District Court that on or about November 9, 1999, between six and twelve guards equipped in riot gear forcibly removed Dr. Sell from his cell, dragged him down the stairs by chains wrapped behind his back, shackled his hands and legs to a heavy object inmates refer to as the "black box," and injected him with a drug that left him unconscious for perhaps as long as a day. (Record 740). Although the incident was videotaped, the Bureau of Prisons has denied Dr. Sell's repeated direct requests for the videotapes and his repeated Freedom of Information Act requests. On another occasion, Dr. Sell has complained that a Center guard attached a hose to a hot water spigot and sprayed Dr. Sell with scalding water while Dr. Sell was locked in the narrow confines of the cage in which he was forced to shower and hence unable to avoid the spray of water.

VII. Dr. Sell's Potential Release.

If Dr. Sell does not become competent, either because involuntary antipsychotic medication is not ordered, or because involuntary medication takes place but does not work, he will not be automatically released. Title 18 U.S.C. § 4241, under which Dr. Sell was hospitalized, states that in such a case a defendant is subject to the provisions of 18 U.S.C. § 4246. Under section 4246, if a defendant is due for release but deemed dangerous to other persons or their

property, the director of the Center is to inform the clerk of the district court and a hearing on this issue must take place. If a finding of future dangerousness is made, the defendant is committed to the custody of the Attorney General or a suitable state facility and semi-annual status reports are required.

SUMMARY OF ARGUMENT

Dr. Sell remains an innocent man – he has never been convicted of any crime – and the government has nonetheless imprisoned him for almost five years without a trial. Even though Dr. Sell has not been found to pose a risk of harm to himself or others, the government seeks to violate his First, Fifth, and Sixth Amendment rights by injecting him – against his will – with permanently mind-altering psychotropic drugs. The government wants to medicate Dr. Sell because it *hopes* that doing so will bring Dr. Sell into an artificially induced, drug-dependent competence, so that the government can bring him to trial on charges involving alleged economic crimes of fraud and money laundering. In other words, the government seeks to justify the deprivation of Dr. Sell's rights on the *chance* that it will be able to prosecute him. Such a constitutionally irreverent justification must be rejected.

In the past, this Court has refused to allow the government to violate an individual's right to bodily integrity when its only motive was a prosecutorial one. In fact, the Constitution only permits intrusions of this magnitude when the life or health of the individual or others is at risk. A citizen cannot be deemed to have forfeited such a fundamental, constitutional right simply based upon the

fact that he is charged with a crime. The government's unconstitutional course of action is particularly egregious because there is no medical consensus that the forced medication of Dr. Sell will result in his competency to stand trial. Even if Dr. Sell did become competent, trial of Dr. Sell in a drug-induced state will result in violations of his Fifth and Sixth Amendment trial rights.

In sum, if the Court of Appeals' decision is allowed to stand, an individual will lose his right to refuse medication based solely upon the government's unproven assertion that the individual is guilty of a non-violent crime and may be rendered competent if non-specified, mind-altering drugs are administered to him. Dr. Sell will also be subjected to potentially long-term and life-threatening side effects caused by the medication. At its core, this case presents the narrow question of whether an innocent individual loses his right to refuse psychotropic medication simply because the government has elected to charge that individual with a crime. Constitutionally, the answer to this question must be no.

ARGUMENT

I. An Innocent Individual Has A Fundamental Right Which Prohibits The Government From Injecting Him With Permanently Mind-Altering, Psychotropic Drugs Against His Will Solely Because It Believes That There Is A Chance To Medicate The Individual Into Drug-Induced "Competence" For Trial.

The right to be free from unwanted physical and mental intrusions has long been recognized as an integral

part of an individual's constitutional freedom – whether it is articulated under the First Amendment as freedom of thought, right to bodily integrity, right to refuse unwanted medical treatment, or right to privacy, under the Fifth Amendment due process clause as a liberty interest or right to privacy, or an aspect of the "right to privacy contained in the notions of personal freedom which underwrote the Bill of Rights." *United States v. Charters*, 829 F.2d 479, 491 (4th Cir. 1987); *see also Stanley v. Georgia*, 394 U.S. 557, 565 (1969) (recognizing First Amendment privacy interest); *Roe v. Wade*, 410 U.S. 113, 152-53 (1973) (citing various sources of right to privacy); *Planned Parenthood v. Casey*, 505 U.S. 833, 852 (1992) (recognizing fundamental right for woman to have abortion); *Griswold v. Connecticut*, 381 U.S. 479, 482-86 (1965) (recognizing right to use contraceptives is fundamental); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990). Although this Court has never specifically ruled that the right to be free from unwanted medical treatment is a *per se* fundamental right, it has recognized a fundamental freedom in one's bodily integrity.[3] The Court should

[3] *See Cruzan*, 497 U.S. 304-05 (1990) (Brennan, J., dissenting) (stating that majority failed to consider whether right to bodily integrity was fundamental); *Riggins v. Nevada*, 504 U.S. 127, 136 (1992) (stating Court could not reach question of substantive rights); *Washington v. Harper*, 494 U.S. 210, 221 (1990) (assuming, without deciding, that right to refuse medication is at least substantial); *Mills v. Rogers*, 457 U.S. 291, 301 (1982) (recognizing a liberty interest in avoiding unwanted administration of drugs, but deferring to state court to determine whether forced medication is unconstitutional under state constitution); *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997); *Casey*, 505 U.S. at 852 (finding fundamental right for woman to have abortion); *Griswold*, 381 U.S. at 485 (recognizing right to use contraceptives is fundamental); *Rochin v. California*, 342 U.S. 165, 171-74 (1952)

(Continued on following page)

explicitly declare, in line with its prior decisions, that the right to be free from compelled medication by the government is fundamental.

A. The Court of Appeals' decision should be reversed because the rights to liberty, bodily integrity, freedom of thought, and privacy are fundamental rights, and the Court of Appeals erred in failing to recognize these fundamental rights.

The existence of a fundamental right must be examined in the light of "our Nation's history, legal traditions, and practices." *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997). The intrusion the government desires to impose on Dr. Sell implicates four intertwined rights which have long been recognized in this nation: his right to bodily integrity, his freedom of thought, his right to privacy, and his liberty interests.

Right to bodily integrity. Even before the ratification of the Constitution, the common law recognized that the touching of a person without consent or legal justification constituted a battery. *See Cruzan*, 497 U.S. at 269. Considering this Court's rulings in other cases against the backdrop of the common law, it becomes quite plain that forcibly medicating a non-violent detainee involves a fundamental right.

As early as 1891, this Court recognized that the Constitution protects a liberty interest in the integrity of

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(finding government cannot force individual to take an emetic based on suspicion that individual swallowed morphine capsules).

one's own body. *Union Pac. R.R. Co. v. Botsford*, 141 U.S. 250 (1891). Indeed, in *Cruzan*, this Court later acknowledged that an individual has a liberty interest in refusing unwanted medical treatment, which is protected by the Constitution. *Cruzan*, 497 U.S. at 278-79. Speaking through Chief Justice Rehnquist, this Court held:

> [N]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Id. at 269 (citations omitted). "Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination," state incursions into the body are deemed repugnant to the interests protected by the Constitution. *Id.* at 287 (O'Connor, J., concurring); *Chandler v. Miller*, 520 U.S. 305, 321-23 (1997) (holding state's requirement that candidates for public office take drug tests unconstitutional).

Not surprisingly, therefore, the trend of modern authority recognizes that an individual has a fundamental right to avoid forced medication. *See United States v. Brandon*, 158 F.3d 947, 957 (6th Cir. 1998) (recognizing fundamental right in avoiding forcible medication); *Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir. 1984) (applying analysis similar to strict scrutiny); *Doe v. Dyett*, No. 84 Civ. 6251-KMW, 1993 WL 378867, at *2 (S.D.N.Y. Sept. 24, 1993) (recognizing right to refuse administration of drugs as fundamental); *Andrews v. Ballard*, 498 F. Supp. 1038, 1045-48 (S.D. Tex. 1980) (stating right to refuse treatment encompassed in right to privacy); *Conservatorship of Wendland*, 28 P.3d 151, 154 (Cal. 2001) (determining

incompetent adult has fundamental right to refuse treatment); *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 15 (Ohio 2000) (finding right to refuse medical treatment is a fundamental right in our country); *Steinkruger v. Miller*, 612 N.W.2d 591, 596-97 (S.D. 2000) (holding persons involuntarily committed have a federal constitutionally protected liberty interest to refuse the administration of psychotropic drugs); *In re Conservatorship of Foster*, 547 N.W.2d 81, 85 (Minn. 1996) (finding the right to be free from intrusive medical treatment is a fundamental right); *In re C.E.*, 641 N.E.2d 345, 351-52 (Ill. 1994) (same); *Rasmussen by Mitchell v. Fleming*, 741 P.2d 674, 682 (Ariz. 1987) (same); *In re Schuoler*, 723 P.2d 1103, 1107-08 (Wash. 1986) (same).

Freedom of thought. This Court has long recognized that freedom of thought is protected by the First Amendment and recently reiterated that "the right to think is the beginning of freedom." *Ashcroft v. Free Speech Coalition*, 122 S. Ct. 1389, 1403 (2002). In fact, "the individual's freedom of conscience [is] the central liberty that unifies the various clauses in the First Amendment." *Wallace v. Jaffree*, 472 U.S. 38, 50 (1985); *see also Stanley*, 394 U.S. at 564; *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (recognizing that the Constitution protects "Americans in their beliefs, their thoughts, their emotions, and their sensations"). As this Court recognized, the scrupulous protection of constitutional freedoms prevents the "strangl[ing of] the free mind at its source." *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624, 637 (1943).

In *Stanley*, the Court decided whether an individual has a constitutional right to possess obscene material in his home. The *Stanley* Court did not base its decision on

the narrow First Amendment principle that an individual has a right to receive information. Instead, the Court recognized a broader principle: the government cannot control the minds of its citizens. *Stanley*, 394 U.S. at 565. It follows, *a fortiori*, that if the government is prohibited from inquiring into the contents of one's library, it certainly must be prohibited from "impermissible tinkering with the mental processes." *Mackey v. Procunier*, 477 F.2d 877, 878 (9th Cir. 1973) (recognizing that unconsented-to treatment with the drug succinycholine would be unconstitutional). "Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds." *Stanley*, 394 U.S. at 565 (recognizing First Amendment privacy interest). This "heritage" compels the reversal of the opinions below.

Lower courts have long held that the involuntary administration of drugs affecting a person's mental processes may amount to an interference with an individual's First Amendment rights. *See Scott v. Plante*, 532 F.2d 939, 946 (3d Cir. 1976); *Mackey*, 477 F.2d at 878; *Lojuk v. Quandt*, 706 F.2d 1456, 1465 (7th Cir. 1983) (recognizing that electroconvulsive therapy may violate First Amendment interests). The use of antipsychotic drugs will permanently alter Dr. Sell's brain chemistry, yet the government has presented no conclusive evidence that the forced medication of Dr. Sell will result in his competency. Further, even if the drugs did make Dr. Sell competent, he could be subjected to a myriad of side effects that further affect his ability to think and function and which could cause him harm. *Bee*, 744 F.2d at 1394 (finding that antipsychotic drugs "have the capacity to severely and even permanently affect an individual's ability to think

and communicate"). Dr. Sell's fundamental right to freedom of thought must be protected.

Liberty and privacy interests. While the liberty guaranteed by the Fifth Amendment has not been defined with exactness, the concept has been recognized to include the right of an individual to be free from governmental intrusion into fundamental matters. *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (finding liberty interest in right of unmarried couples to use birth control); *see also Loving v. Virginia*, 388 U.S. 1, 12 (1967) (recognizing due process liberty interest protects right to marry); *Carey v. Population Servs., Int'l*, 431 U.S. 678, 684-86 (1977); *Griswold*, 381 U.S. at 481-86 (finding liberty interest in right of married couple to use birth control). Thus, the substantive component of the due process clause protects individual liberty against certain government actions regardless of the perceived fairness of the procedures used to implement them. In *Albright v. Oliver*, 510 U.S. 266 (1994), this Court specifically noted that the protections of substantive due process "have for the most part been accorded to matters relating to marriage, family, procreation, and *the right to bodily integrity*." 510 U.S. 266, 272 (1994) (citations omitted) (emphasis added); *see also Bee*, 744 F.2d at 1393 (finding individual has a liberty interest in being free from forced medication).

A right is fundamental when it involves "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *See Casey*, 505 U.S. at 851. Determinations about one's own psychology, one's own mental state, and about one's own physical integrity are undoubtedly the most important personal decisions an individual can make. This Court has stated: "At the heart of liberty is the right to

define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Id.* In sum, whether the label attached to Dr. Sell's interest is freedom of thought, privacy, right to bodily integrity, or a liberty interest, Dr. Sell has a fundamental right to avoid the forced administration of antipsychotic drugs.

Even if this Court determines that Dr. Sell's right to avoid compelled medication is not fundamental, due process still prohibits the conduct advocated by the government here. Due process requires that this Court ascertain whether the government's conduct "offend[s] those canons of decency and fairness which express the notions of justice of English-speaking peoples, even those charged with [criminal] offenses." *Rochin*, 342 U.S. at 169. This Court has recognized that the Constitution protects "fundamental human dignity" and evidences the "evolving standards of decency that mark the progress of a maturing society." *See Ford v. Wainwright*, 477 U.S. 399, 406 (1986) (finding that Eighth Amendment prohibits execution of an insane individual); *see also Foucha v. Louisiana*, 504 U.S. 71 (1992) (recognizing that due process prohibits "arbitrary, wrongful government actions"). Allowing the government's prosecutorial might to extend into physical intrusions into an individual's mind violates the minimum standards of due process, particularly where, as here, the government has not indicated the drugs it would administer, making a complete evaluation of the deprivation impossible.

B. The Court of Appeals' ruling must be reversed because the forced administration of mind-altering, psychotropic drugs is an irreversible intrusion into an individual's freedom of thought, liberty interests, privacy interests, and bodily integrity.

Although the physical invasion caused by the forced administration of antipsychotic drugs is achieved through the mere injection of a needle, the impact of psychotropic drugs upon the brain is "mind altering" and "sufficient to undermine the foundations of personality." *In re Guardianship of Roe*, 421 N.E.2d 40, 52, 53 (Mass. 1981); *Mills*, 457 U.S. at 293 n.1; *Cochran v. Dysart*, 965 F.2d 649, 650 (8th Cir. 1992). In fact, there are few medical procedures "which are more intrusive than the forcible injection of antipsychotic drugs." *In re Roe*, 421 N.E.2d at 52. As one court aptly noted:

> We have little doubt that if the medical treatment at issue here was psychosurgery, such as lobotomy, it would be readily apparent that very significant interests concerning freedom of thought were implicated. . . . There is [] no principled distinction between the chemical invasion of drug therapy and the mechanical invasion of surgery.

Charters, 829 F.2d at 489.

Not only do antipsychotic drugs suppress the symptoms of mental illness, they also "affect the well functioning aspects of personality." *Id.* Here the record reflects that, as a result of being medicated, Dr. Sell may develop tardive dyskinesia, a permanent condition which may cause Dr. Sell to have abnormal motor movements. (App. 186). Dr. Sell may also develop neurolectic malignant

syndrome, a potentially fatal condition that can cause a person to appear awake, but be listless and dazed. (App. 187). At best, the government cannot be sure of the effect because it does not state (and has not been required to state) which drugs it would use.

In any case, the significant intrusion caused by psychotropic drugs does not end with the mind-altering effects. *See* Dennis E. Cichon, *The Right to "Just Say No:" A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283, 297-314 (1992) (describing effects of antipsychotic drugs). Courts have recognized that antipsychotic drugs may cause "serious and irreversible injury in a significant percentage of cases." *Charters*, 829 F.2d at 478. "While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects." *Harper*, 494 U.S. at 229. Antipsychotic drugs carry a significant risk of adverse side effects, including

> neurological syndromes as parkinsonisms, characterized by a mask-like face, retarded volitional movements, and tremors; akathisia, a clinical term for restlessness; dystonic reactions, including grimacing and muscle spasms; and tardive dyskinesia, a disease characterized in its mild form by involuntary muscle movements, especially those around the mouth. Tardive dyskinesia can be even more disabling in its most severe forms.

Mills, 457 U.S. at 293 n.1. As Justice Stevens recognized in *Harper*: "The invasion [of a person's bodily integrity] is particularly intrusive if it creates a substantial risk of permanent injury and premature death." 494 U.S. at 237 (Stevens, J., concurring in part and dissenting in part).

Thus, because of the possibly long-lasting effects of the drugs, once the government is permitted to infringe upon Dr. Sell's rights, the infringement could well be a permanent one.

The government's attempt to medicate is particularly troubling because Dr. Sell has never been adjudged incompetent to make medical decisions. The fact that Dr. Sell has been found incompetent to stand trial does not determine whether he is competent to make medical decisions. *Charters*, 829 F.2d at 495. "[T]he law will presume sanity rather than insanity, competency rather than incompetency; [and] . . . that every man is sane and fully competent until satisfactory proof to the contrary is presented." *Id.* (citations omitted). Because the law assumes an individual is competent until declared otherwise, Dr. Sell's decision regarding whether to be medicated should be honored.[4]

[4] Under no circumstances, however, would a prosecutor be the proper party to make Dr. Sell's medical decisions. If Dr. Sell was found incompetent to make his medical decisions, a guardian should be appointed to make them. *See* Jeanne Louise Carriere, *Reconstructing the Grounds for Interdiction*, 54 LA. L. REV. 1199, 1199 n.4 (1994) ("Traditionally, in common law, a finding of 'non compos mentis or incompetence' led to the appointment of a guardian. . . .") (citing Prefatory Note, UNIF. GUARDIANSHIP AND PROTECTIVE PROCEEDINGS ACT, 8A U.L.A. 441 (1982)). Even if a guardian is appointed, Dr. Sell's desire to withhold consent for medication is critical: "The guardian must consider the ward's expressed desires and personal values when making decisions." Prefatory Note, UNIF. GUARDIANSHIP AND PROTECTIVE PROCEEDINGS ACT (1997), 8A U.L.A. 113 (1993 & Supp. 2002).

II. The Government's Interest In Trying Dr. Sell Does Not Override His Fundamental Right To Remain Free From Forced Medication And From Being Subjected To The Serious Side Effects Resulting Therefrom.

A determination that an individual possesses a fundamental right does not end the inquiry of whether a person's constitutional rights have been violated. In applying strict scrutiny, the Court must balance the individual's liberty interest against the government's stated interests. *See Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (finding strict scrutiny required when considering sterilization laws). As the impact of the decision on the life of the individual increases, so must the importance of the government's interest. Therefore, when fundamental rights are at stake, the government must prove that it has a compelling interest significant enough to override the individual's interest and that it is using the least restrictive means possible to effectuate its interest. *See Skinner*, 316 U.S. at 541. Here, the government's interest is not sufficiently compelling to override Dr. Sell's fundamental rights because: (1) this Court has never before allowed an intrusion this invasive solely for prosecutorial purposes; (2) the government's interest is severely diminished (if not vitiated) by the uncertainty of whether any medication will render Dr. Sell incompetent; (3) the government's interest in bringing Dr. Sell to trial will not be met if he is heavily medicated during the trial; and (4) the government's interests are lessened even further by the nonviolent nature of the crime and the fact that Dr. Sell is not a danger to himself or others.

The government wishes to override Dr. Sell's fundamental right to be free from bodily intrusion under

the First and Fifth Amendments, so that it can try him for what amounts to charges of insurance fraud.[5] While this Court has never considered whether the government can violate a pretrial detainee's constitutional rights without asserting any penological objectives, this Court's prior rulings mandate the constitutional answer. It is well-established that the government may detain a person suspected of committing a crime prior to an adjudication of guilt. *See Gerstein v. Pugh*, 420 U.S. 103, 111-14 (1975). Obviously, however, prior to conviction an individual committed to pretrial detention has not been adjudged guilty of any crime. While incarcerated, therefore, a pretrial detainee must be presumed to be innocent of alleged, prior criminal conduct. *See Estelle v. Williams*, 425 U.S. 501, 503 (1976); *Bell v. Wolfish*, 441 U.S. 520, 582 (1979) (Stevens, J., dissenting). "The principle that there is a presumption of innocence in favor of the accused is the undoubted law, axiomatic and elementary, and its enforcement lies at the foundation of the administration of our criminal law." *Coffin v. United States*, 156 U.S. 432, 453 (1895).

Government's sole motive is prosecutorial. Allowing the forced medication of Dr. Sell would grant the government unprecedented power, as this Court has never allowed such an intrusive invasion solely for a prosecutorial purpose. *See Ferguson v. Charleston*, 532 U.S. 67, 86 (2001) (holding testing pregnant women for drugs solely

[5] The violation of Dr. Sell's constitutional rights is further compounded by the fact that the government does not have legal custody over Dr. Sell. *Sell*, 282 F.3d at 573 (Bye, dissenting) (finding sentencing range to be 33 to 41 months).

for prosecutorial purpose is unconstitutional); *Winston v. Lee*, 470 U.S. 753, 767 (1985); *Rochin*, 342 U.S. at 171-74. In *Riggins*, Justice Kennedy noted:

> [A]bsent an extraordinary showing by the State, the Due Process Clause prohibits prosecuting officials from administering involuntary doses of antipsychotic medicines for purposes of rendering the accused competent for trial.

504 U.S. at 139 (Kennedy, J., concurring) (expressing doubt that the government will be able to make such a showing in most cases). Importantly, in this Court's jurisprudence where physical intrusions of the body were permitted, the Court also has recognized that the outcome would have been different had the effects of the intrusion been permanent. *See Schmerber v. California*, 384 U.S. 757, 772 (1966). For example, in *Schmerber*, which allowed the compelled tests of an accident victim's blood alcohol content, the Court reiterated: "[t]hat we today hold that the Constitution does not forbid the State's minor intrusions into an individual's body under strictly limited conditions in no way indicates that it permits more substantial intrusions, or intrusions under other conditions." *Id.* In this case, there is real potential for permanent adverse effects. Further, it is clear that this Court's prior jurisprudence only allows the government to medicate an individual against his will if the individual's safety or the safety of others is at stake. *See Riggins*, 504 U.S. at 135 (finding medication appropriate if "essential for the sake of Riggins' own safety or the safety of others"); *Addington v. Texas*, 441 U.S. 418, 425-26 (1979) (providing standard for civil commitment and requiring that person be danger to himself or others). The safety interest present in *Riggins* is not present in Dr. Sell's case.

Moreover, and pertinent here, this Court has specifically rejected the idea that a person who is incompetent to stand trial can be treated differently than non-accused incompetent individuals, simply based on the fact that the government has charged him with a crime. *Jackson v. Indiana*, 406 U.S. 715, 729-30 (1972) (finding state may not have lower standard for civil commitment for individuals accused, but not convicted, of crimes). The District Court opinion and the Court of Appeals' panel opinion afford Dr. Sell, a pretrial non-dangerous detainee, fewer due process rights than those afforded convicted felons under established law. A convicted felon cannot be involuntarily medicated unless he is a danger to himself or others within the prison setting and the medication is deemed medically appropriate. *Harper*, 494 U.S. at 227. By permitting the involuntary medication of a non-dangerous pretrial detainee, the courts below fashioned a test that affords an individual presumed innocent with fewer rights and protections than those of a convicted individual who can only be medicated if dangerous.

Thus, several courts have determined that the government's interest in rendering the detainee competent did not justify administration of medication involuntarily. *See Cochran*, 965 F.2d at 651 (recognizing a prisoner cannot be forcibly medicated against his will when not a danger to himself or others); *Woodland v. Angus*, 820 F. Supp. 1497, 1511 (D. Utah 1993); *United States v. Santonio*, No. 2:00-CR-90C, 2001 WL 670932, at *4 (D. Utah May 3, 2001) (same); *see also State v. Perry*, 610 So. 2d 746, 771 (La. 1992) (finding a prisoner cannot be medicated so that he can be executed).

Uncertain outcome. The government's interest is further diminished by the uncertainties of the medication

and the side effects thereof. There is no certainty that Dr. Sell will become competent if medicated. One of the government's witnesses, DeMier (a psychologist who cannot prescribe medication) testified that he had only treated two patients with delusional disorder and had only been successful in making one of the two competent. (App. 174-75).[6] Moreover, the efficacy of antipsychotic drugs in cases of delusional disorder is uncertain at best. (App. 345 (Judge Stohr acknowledging the disagreement among experts)). There were three sources of evidence on the question of the medical appropriateness of psychotropic medication for individuals suffering from delusional disorder presented at the hearing before the magistrate judge: the testimony of the Bureau of Prisons witnesses, DeMier and Dr. Wolfson; Dr. Robert Cloninger, who testified via affidavit; and a report from Dr. Greenstein from the Federal Bureau of Prisons, Metropolitan Correctional Center, a forensic psychologist. While government witnesses DeMier and Dr. Wolfson, who were advocating medicating Dr. Sell, testified that the use of antipsychotic medication was medically appropriate, Dr. Cloninger's testimony was clear that "there is no evidence that [antipsychotic medications] are beneficial for patients with Delusional Disorder." (Record 414). Similarly, Dr. Greenstein stated in his report that delusional disorders do not typically respond to medication or psychotherapy. (App. 216-17). In fact, the very text relied upon by DeMier and Dr. Wolfson as authoritative, (App. 211, 260-61), the

[6] Because Dr. Sell has not been given the names, diagnosis, or treatment for either one of these individuals, Dr. Sell was unable to test or verify the accuracy of DeMier's statements.

COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, states that there are no controlled studies reported to support the practice of treating delusional disorder with antipsychotic medication. (Record 978).

Ordering involuntary medical treatment presupposes that the treatment is medically appropriate, *Riggins*, 504 U.S. at 127, which is not the case here. There is no basis in the record for such a conclusion. Given the severity of the potential effects of forced medication, the government's position that it *might* be able to make Sell competent should be given little weight.

Heavily medicated defendant. Although Dr. Sell does not downplay the importance of the government's interest in trying individuals accused of crimes, it is questionable that the government's objective will be met by trying a heavily medicated defendant, especially when that person has already been in custody longer than allowable on the insurance fraud charges.[7] The government admits that if it medicates Dr. Sell, the side effects of the drugs may cause Dr. Sell to be unable to control his facial muscles or may cause Dr. Sell to appear dazed and listless. As discussed in Section III, *infra*, these side effects will constitutionally impair Dr. Sell's trial rights. The

[7] Further, the government has not tried less intrusive means of making Dr. Sell competent. At the hearing, DeMeir testified that Dr. Sell was not receiving any treatment for his condition and that Dr. Sell was being kept in solitary confinement, which may be exacerbating his mental illness. (App. 180-81, 188). "I should think that any alternative would be less intrusive than toying with an accused's brain chemistry." *Riggins v. Nevada*, 860 P.2d 705, 707 (Nev. 1993) (Springer, J., dissenting).

government's interest in bringing a defendant to a fatally flawed trial are minimal, at best.

Non-violent crime and non-dangerousness. The government's interest is lessened even further because the government's only basis for medicating Dr. Sell is the government's belief that Dr. Sell is guilty of non-violent crimes, involving only economic losses. This interest cannot be compelling enough to overcome Dr. Sell's constitutional rights.[8] Although the government possesses an interest in bringing a defendant to trial, not "every charge is sufficient to justify forcible medication of a defendant." *See Sell*, 282 F.3d at 572 (Bye, J., dissenting) (finding charges against Dr. Sell insufficient to justify forcible medication). While the Eighth Circuit panel also recognized that "[n]ot all charges . . . are sufficient to justify forcible medication of a defendant," it cursorily determined that the charges against Dr. Sell are "serious" and that Dr. Sell's interest in avoiding forced medication is outweighed by the government's essential interest. *Sell*, 282 F.3d at 568. The Eighth Circuit's one-sentence examination of the nature of the crimes for which Dr. Sell was indicted does not pass constitutional muster.

The government cannot present a compelling interest when the defendant is charged with a non-violent crime. *See Brandon*, 158 F.3d at 961 (finding government's interest in prosecuting individual for sending threatening mail is not compelling enough); *Bee*, 744 F.2d at 1395 (questioning whether the state's interest in trying suspects

[8] The government's interest in even further diminished, considering that the statute specifically contemplates civil commitment as an alternative remedy. *See* 18 U.S.C. § 4246(b).

could ever outweigh the individual's interest in avoiding forcible treatment with antipsychotic drugs and stating "[t]he needs of the individual, not the requirements of the prosecutor, must be paramount where the use of antipsychotic drugs is concerned"). As noted by the dissenting judge of the Nevada Supreme Court after remand in *Riggins*: "[W]hen I balance the need to bring insane persons to justice against the ignominy of forcing mind-altering drugs down the throats of persons who are presumed to be innocent, I opt in favor of the rights of the individual as against the rights of the State." *Riggins*, 860 P.2d at 706 (Springer, J., dissenting).

Dr. Sell respectfully submits that, because the effects of psychotropic drugs on an individual may cause permanent changes in brain chemistry and muscular control, forcibly medicating that individual for the sole purpose of inducing "competence," when the individual has not been found guilty of a crime (and who still must enjoy the presumption of innocence), can only be justified by a government interest of the highest order. Dr. Sell's rights under the common law and under the Constitution were not extinguished simply because the government charged him with a crime.

Indeed, this Court has previously held that prosecutorial motive alone is not enough to violate an individual's constitutional rights. *Winston*, 470 U.S. at 766-67 (holding government's desire to prosecute defendant did not outweigh defendant's Fourth Amendment rights); *Rochin*, 342 U.S. at 171-74 (finding that requiring an individual to ingest an emetic so that police could obtain drugs is unconstitutional). The government does not have a compelling interest in forcing Dr. Sell to be subjected to mind-altering medications so that it can try him for a non-violent crime, the trial for which is likely to be

constitutionally contaminated by the effects of the very drugs the government now seeks to force upon Dr. Sell.

III. Dr. Sell Has Fundamental Trial Rights Under The Fifth and Sixth Amendments Not To Be Medicated Into Drug-Induced, Synthetic Sanity.

Dr. Sell's trial rights as guaranteed by the Fifth Amendment and Sixth Amendment include the rights (1) to present a defense, including a diminished capacity defense, *see* FED. R. CRIM. P. 12.2(b); (2) to not have the government manipulate his appearance in a way that prejudices him before the jury, *Illinois v. Allen*, 397 U.S. 337, 345 (1970); (3) to not be tried unless he is competent to "consult with counsel, and to assist in preparing his defense," *Drope v. Missouri*, 420 U.S. 162, 171 (1975); and (4) to testify and "present his own version of events in his own words," *Rock v. Arkansas*, 483 U.S. 44, 52 (1987). Moreover, the government cannot suppress "evidence favorable to an accused . . . where the evidence is material either to guilt or to punishment." *Brady v. Maryland*, 373 U.S. 83, 87 (1963). All of these rights would be violated if Dr. Sell is tried while compulsorily medicated.

Right to present defense. Antipsychotic medication affects the defendant's ability to assist in his defense and, in essence, forces the accused to provide the jury with a coerced confession of his mental state. *See Riggins*, 504 U.S. at 137; *id.* at 143 (Kennedy, J., concurring); *Rochin*, 342 U.S. at 175 (Black, J., concurring) (finding person is compelled to be witness against himself when "incriminating evidence is forcibly taken from him by contrivance of modern science"). In a case where diminished capacity is raised as a defense, the jury must assess their belief about defendant's mental state at the time the crime occurred.

"[I]f the defendant appears calm and controlled at trial, the jury may well discount any testimony that the defendant lacked, at the time of the crime, substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law." *People v. Hardesty*, 362 N.W.2d 787, 796 (Mich. Ct. App. 1984). The accused, sitting in the courtroom drugged and listless, becomes an instrument of his own conviction, with his calm and controlled demeanor rebutting his own case without a single word being uttered.

Further, compulsory medication of a defendant makes it easier for the government to rebut the accused's defense of diminished capacity by suppressing the most persuasive evidence of the individual's demeanor at the time the crime occurred. Due process does not allow the government to suppress "evidence favorable to an accused . . . where the evidence is material to either guilt or punishment." *Brady*, 373 U.S. at 87. As this Court has recognized, "the most important witness for the defense in many criminal cases is the defendant himself." *See Rock*, 483 U.S. at 52. After antipsychotic drugs are administered, the defendant is deprived of the best evidence of his mental state at the time of the alleged crime – his own demeanor in an unmedicated state. Postmedication review of an individual's Sixth Amendment rights may come too late to prevent impairment of that right. *See United States v. Weston*, 206 F.3d 9, 14 (D.C. Cir. 2000).

Right to not have government manipulate appearance. Further, the right to a fair trial also means that one accused of a crime "is entitled to have his guilt or innocence determined solely on the basis of the evidence introduced at trial." *Taylor v. Kentucky*, 436 U.S. 478, 485 (1978). If the government alters Dr. Sell's outward appearance by medicating him with drugs that cause numerous

side effects affecting his demeanor, it will fatally flaw any criminal proceedings against him. *See Allen*, 397 U.S. at 344-45 (finding sight of shackles will have significant effect on the jury's feelings about defendant); *Estelle*, 425 U.S. at 504 (finding it unconstitutional to require accused to appear at trial in prison uniform); *Spain v. Rushen*, 883 F.2d 712, 720-21 (9th Cir. 1989) (finding defendant unable to meaningfully participate in trial due to shackles and shackles caused prejudice with jury); *State v. Maisonet*, 763 A.2d 1254, 1260 (N.J. 2001) (stating that defendant was denied fair trial when forced to appear in court disheveled based on police's failure to provide him with a comb and soap).

In *Illinois v. Allen*, this Court ruled that requiring a prisoner to appear before the jury in shackles "might have a significant effect on the jury's feelings about the defendant, but the use of this technique is itself something of an affront to the very dignity and decorum of judicial proceedings that the judge is seeking to uphold." 397 U.S. at 344. If requiring an accused to appear in court in shackles or disheveled violates an individual's rights, certainly the government cannot alter the detainee's appearance by forcing him to take drugs that make him appear nervous and anxious or rigid and remorseless.

Right to confront witnesses and participate in defense. Although it may be argued that the administration of drugs makes it more likely that the individual will be able to participate in his trial, this view forgets the side effects caused by the medication. These side effects will affect Dr. Sell's ability to pay attention to witnesses, attorneys, or anyone else in the courtroom, to listen and respond to questions, and to offer comments about the proceedings. The pace of criminal proceedings requires an

individual to be able to listen to information from multiple sources and interact with counsel fairly rapidly. The side effects of the psychotropic drugs could significantly hamper Dr. Sell's ability to do so.

Right to testify in own defense. Dr. Sell's ability to testify in his own defense, if he so chooses, will also be hampered as Dr. Sell will be faced with a Hobson's choice: testify and hope that the jury is not improperly swayed by the listlessness or stiffness resulting from the medication or refuse to testify and risk that the jury is still improperly affected by these same considerations. Trying Dr. Sell, while under compelled medication, violates his Fifth and Sixth Amendment trial rights.

Further, unlike Dr. Sell's right to bodily integrity protected by the First and Fifth Amendments, Dr. Sell's trial rights under the Fifth and Sixth Amendment are not to be balanced against the government's interest in bringing him to trial. Rather, the "probability of deleterious effects" on fundamental trial rights "calls for close judicial scrutiny." *Estelle*, 425 U.S. at 504. Thus, unless an accused somehow waives his Fifth and Sixth Amendment trial rights, the violation of these rights will not be excused unless they constitute harmless error. *Id.* at 507. Given the numerous effects medication will have on Dr. Sell's trial rights, the government cannot show that forced medication would constitute harmless error.[9]

[9] Even if the government's attempts to drug Dr. Sell do not violate the Constitution, this Court should use its supervisory powers to prohibit the standardless drugging of Dr. Sell. "Judicial supervision of the administration of criminal justice in the federal courts implies the duty of establishing and maintaining *civilized standards of*

(Continued on following page)

IV. The Forced Medication Of Dr. Sell Would Violate His Fifth Amendment Procedural Due Process Rights.

A. Dr. Sell's Fifth Amendment due process rights were violated because the government was not required to prove its case by clear and convincing evidence.

This Court has not decided the issue of the government's burden of proof when it seeks involuntary medication of a pretrial detainee. Lower court and state court decisions on this issue require various burdens of proof, and many courts do not discuss the government's burden of proof when addressing forced medication issues. *See United States v. Gomes*, 289 F.3d 71, 88 (2d Cir. 2002) (failing to discuss burden of proof); *Brandon*, 158 F.3d at 960-61 (requiring proof by clear and convincing evidence); *State v. Garcia*, 658 A.2d 947, 967 (Conn. 1995) (requiring

procedure. . . . " *McNabb v. United States*, 318 U.S. 332, 340 (1943) (emphasis added). Acting under its supervisory power, this Court " 'may formulate procedural rules not specifically required by the Constitution or Congress,' " *United States v. Awadallah*, 202 F. Supp. 2d 17, 52 (S.D.N.Y. 2002) (quoting *United States v. Hasting*, 461 U.S. 499, 505 (1983)), including rules designed to "preserve judicial integrity by ensuring that a conviction rests on appropriate considerations validly before the jury," *Hasting*, 461 U.S. at 505.

If the drugging of Dr. Sell is allowed, the jury will have before it a defendant whose appearance, demeanor, testimony, and assistance with and participation in his defense will have been altered. Moreover, permitting the government to engage in "drug first, evaluate later" tactics, especially in violation of Dr. Sell's Sixth Amendment rights, contradicts "civilized standards of procedure" – standards which "are not satisfied merely by observance of those minimal historic safeguards. . . . " *McNabb*, 318 U.S. at 340. The involuntary medication of Dr. Sell violates foundational standards of due process of law, "below which we reach what is really trial by force." *Id.*

proof by clear and convincing evidence); *Kheim v. United States*, 612 A.2d 160, 172 (D.C. Cir. 1992) (adopting medical judgment standard).

Dr. Sell's case exemplifies the confusion in the courts regarding the burden of proof to be applied. While the District Court affirmed the magistrate judge's use of a "substantial and very strong showing" standard, the Court of Appeals required the government to prove, by clear and convincing evidence, that the medication is appropriate. (*See* App. 333, 354, 366-67). It is unclear what burden of proof the government is required to meet for the remaining two factors in the Court of Appeals' three-part test.

This Court, however, has mandated that the government prove its case by clear and convincing evidence when "the individual interests at stake in a state proceeding are both particularly important and more substantial than mere loss of money." *Cruzan*, 497 U.S. at 282 (citations omitted). Thus, the Court has required proof by clear and convincing evidence in deportation proceedings, *Woodby v. INS*, 385 U.S. 276, 285-86 (1966); in denaturalization proceedings, *Schneiderman v. United States*, 320 U.S. 118, 153 (1943); and in civil commitment proceedings, *Addington*, 441 U.S. at 433. A defendant's constitutional right of bodily integrity should be granted equal protection with these important rights. Dr. Sell's substantive due process rights were violated when the government was not required to prove all elements of its case by clear and convincing evidence.

B. The forced medication of Dr. Sell does not comport with any notions of due process.

Before injecting a person with antipsychotic drugs, the government must establish, at a minimum, that the medication is necessary and appropriate. *See Harper*, 494 U.S. at 222 n.8. In this case, the government was not even required to inform Dr. Sell or the District Court which type of drugs or dosage it planned on injecting into him.[10] Certainly, a showing of medical appropriateness requires that the government provide the Court and the defendant with the name and proposed dosage of the antipsychotic drug to be administered, so that the defendant can rebut any assertions made by the government.

This Court has "underscore[d] the value to be derived from a factfinder's consideration of differing psychiatric opinions when resolving contested issues of mental state." *See Ford*, 477 U.S. at 414. The adversarial process is especially important in matters of competence because psychiatrists often differ as to the proper treatment for a particular diagnosis. *See id.* The record in this case illustrates that substantial disagreement exists regarding the treatment for delusional disorder. (App. 30, 345). Without knowledge of the drugs to be used and the dosage of those drugs, Dr. Sell has been denied the ability to fully question and rebut the opinions offered by the government's witnesses. The standardless drugging of pretrial detainees,

[10] It must also be questioned whether physicians employed by the government can truly make an independent determination that medication is in a pretrial detainee's best interest.

without the normal safeguards of a full and fair adversarial process, cannot comport with due process.

CONCLUSION

For the foregoing reasons, Dr. Sell respectfully requests that the Court rule that forced administration of antipsychotic drugs for the sole purpose of prosecuting him for a non-violent crime violates his First, Fifth, and Sixth Amendment rights.

Respectfully submitted,

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No. 02-5664

In the Supreme Court of the United States

CHARLES THOMAS SELL, PETITIONER

v.

UNITED STATES OF AMERICA

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES

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QUESTION PRESENTED

The Court granted certiorari limited to the following question:

Whether the court of appeals erred in rejecting petitioner's argument that allowing the government to administer antipsychotic medication against his will solely to render him competent to stand trial for non-violent offenses would violate his rights under the First, Fifth, and Sixth Amendments.

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In the Supreme Court of the United States

No. 02-5664

CHARLES THOMAS SELL, PETITIONER

v.

UNITED STATES OF AMERICA

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES

OPINIONS BELOW

The opinion of the court of appeals (J.A. 356-382) is reported at 282 F.3d 560. The order of the district court (J.A. 339-355) is unreported. The memorandum and order of the magistrate judge (J.A. 320-338) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 7, 2002. A petition for rehearing was denied on May 7, 2002 (J.A. 383). The petition for a writ of certiorari was filed on August 2, 2002, and was granted on November 4, 2002, limited to the question specified by the Court. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The relevant constitutional, statutory, and regulatory provisions are reprinted in an appendix to this brief. App., *infra*, 1a-16a.

STATEMENT

1. On May 16, 1997, petitioner, a dentist, was charged in a complaint with making false representations in connection with payments for health care services, in violation of 18 U.S.C. 1035(a)(2). On May 20, 1997, the government filed a motion pursuant to 18 U.S.C. 4241(a) for a psychiatric examination of petitioner to determine his competence to stand trial. After a hearing, a magistrate judge ordered that petitioner be sent to the U.S. Medical Center for Federal Prisoners at Springfield, Missouri (Springfield), for an evaluation under 18 U.S.C. 4241(b). On July 15, 1997, after receiving a psychological evaluation from Springfield, the magistrate judge ruled that petitioner was competent to stand trial. Petitioner was thereafter released. J.A. 357-358.

On November 6, 1997, a superseding indictment was returned charging petitioner and his wife with 56 counts of mail fraud, in violation of 18 U.S.C. 1341; six counts of Medicaid fraud, in violation of 42 U.S.C. 1320a-7b(a)(1)(i); and one count of money laundering, in violation of 18 U.S.C. 1957(a). J.A. 12-22.

On April 23, 1998, a separate indictment was returned charging petitioner and his wife with conspiring to murder a witness and an FBI agent, in violation of 18 U.S.C. 1114; two counts of attempted murder of a federal witness, in violation of 18 U.S.C. 1512(a) and 1513(a); one count of attempted murder of a federal officer, in violation of 18 U.S.C. 1114; and two counts of soliciting violence, in violation of 18 U.S.C. 373. J.A. 23-29, 358. The indictment alleged that petitioner and his wife solicited a person to kill two individuals: the FBI agent who arrested him, and a former employee at his dental office who had cooperated with law enforcement in its fraud investigation and who planned to testify against petitioner on the fraud charges. *Ibid.* On December 3, 1998, following a plea by petitioner's spouse, a superseding indictment was filed against petitioner in the murder conspiracy case. The

attempted murder and fraud cases were joined together for trial. J.A. 358.[1]

2. In February 1999, petitioner's counsel moved for another hearing to determine petitioner's competency to stand trial, and the government moved to have a government psychologist examine petitioner. After a hearing, a magistrate judge entered an order under 18 U.S.C. 4241(b) that petitioner be sent to Springfield for another competency evaluation. On April 14, 1999, after receiving a psychological evaluation from Springfield, the magistrate judge found by a preponderance of the evidence that petitioner was suffering from a mental disease or defect that rendered him incompetent to stand trial because he was unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense. 18 U.S.C. 4241(d). Petitioner's psychiatrist, Dr. Robert Cloninger, and the government's psychologist, Dr. Richart DeMier, diagnosed petitioner with "delusional disorder, persecutory type." J.A. 359.[2]

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[1] Petitioner was originally released on bond. Following allegations that he attempted to intimidate a witness, his bond was revoked, after a hearing at which petitioner's behavior was out of control. J.A. 358 (petitioner "screamed, shouted, and used racial epithets," and "spit directly" in the magistrate judge's face). Petitioner is currently being detained pending trial (and would be so held even without the order committing him under 18 U.S.C. 4241).

[2] "The essential feature of Delusional Disorder is the presence of one or more nonbizarre delusions that persist for at least 1 month." *Diagnostic and Statistical Manual of Mental Disorders* 297.1, at 296 (4th ed. 2000) (DSM IV). The "bizarreness" of the delusion can distinguish delusional disorder from schizophrenia, a mental disorder involving delusions that "are clearly implausible, not understandable, and not derived from ordinary life experiences." *Ibid.* "In contrast, nonbizarre delusions involve situations that can conceivably occur in real life." *Id.* at 297. The persecutory subtype of delusional disorder applies "when the central theme of the delusion involves the person's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously ma-

Pursuant to 18 U.S.C. 4241(d), the magistrate judge ordered that petitioner be hospitalized at Springfield for a reasonable period of time not to exceed four months to determine whether there was a substantial probability in the foreseeable future that he would attain the capacity to stand trial. Upon his return to Springfield, petitioner was under the care of two clinicians, Dr. DeMier, the clinical psychologist, and Dr. James Wolfson, the consulting psychiatrist, who determined that antipsychotic medication was needed in order to render petitioner competent to stand trial. On June 9, 1999, petitioner had an administrative hearing, pursuant to 28 C.F.R. 549.43, before a reviewing psychiatrist, Dr. Charles D. Glazzard, to determine whether petitioner should be involuntarily medicated. J.A. 141-151, 359-361. Dr. Glazzard considered evidence that in 1982 petitioner was diagnosed with schizophrenia following a hospitalization that occurred after he reported a hallucination of a leopard in his office and near a bus. J.A. 146-150, 153. Dr. Glazzard also heard from Dr. DeMier and Dr. Wolfson, who testified that petitioner's "symptoms point[ed] to a diagnosis of Delusional Disorder but also recognize[d] that there well may be an underlying Schizophrenic Process." J.A. 147. Dr. Wolfson believed that "antipsychotic medication [was] indicated" to treat petitioner's psychotic symptoms. *Ibid.*

Petitioner proffered a four-page affidavit of Dr. Cloninger, who stated his view that there was "no evidence that neuroleptics [antipsychotic medications] are beneficial for patients with Delusional Disorder." J.A. 31. Dr. Cloninger opined that "the treatment of [petitioner] should be limited to basic support," including "a safe supportive milieu with access to exercise and reading material," and "voluntary symptomatic treatment" with antidepressants. J.A. 32.

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ligned, harassed, or obstructed in the pursuit of long-term goals." *Id.* at 298.

Following the hearing, Dr. Glazzard concluded that antipsychotic medication was required to restore petitioner's competence to stand trial. J.A. 144-145, 150. Dr. Glazzard also found that other forms of medication or treatment would not alleviate his delusional symptoms. J.A. 151. On July 2, 1999, Sherman Waltner, the Bureau of Prisons reviewing official, denied petitioner's administrative appeal in a written opinion confirming Dr. Glazzard's conclusions. J.A. 152-157. Springfield delayed administration of the medication to give petitioner the opportunity to seek judicial review. J.A. 361.

On September 29, 1999, a magistrate judge conducted an evidentiary hearing to determine whether petitioner should be involuntarily medicated. J.A. 158-319. Dr. DeMier testified that petitioner's condition had deteriorated since June 1999 and would continue to deteriorate if he were not treated with antipsychotic medication. J.A. 165-167, 172. Dr. DeMier stated that the delay in treatment could lengthen the period of necessary treatment and could diminish the optimal response of the treatment. J.A. 165, 216. Based on petitioner's conduct at Springfield and his history, Dr. DeMier believed that petitioner was dangerous. J.A. 172-174.

Dr. DeMier opined that "anti-psychotic medication [was] clearly indicated, as it [was] the only treatment that we could reasonably expect to improve [petitioner's] condition." J.A. 176. He believed that there was not "any other effective method of treating [petitioner's] symptoms at this time," J.A. 177, and that antipsychotic medication was "the only effective means to improve his mental state." J.A. 184. He also believed that petitioner could "be restored to competency, as a result of treatment with anti-psychotic medications." J.A. 176. Dr. DeMier testified that he had been involved in the treatment of two patients with delusional disorder who had been administered antipsychotic medication and that one patient had regained competency and the

other had shown significant improvement. J.A. 174-176, 184-185. Dr. DeMier acknowledged that there were "potentially significant side effects" from the medication, such as tardive dyskinesia (from long-term use) and neuroleptic malignant syndrome (in very rare instances). J.A. 185-188.

Dr. Wolfson, the consulting psychiatrist, agreed that petitioner was psychotic and that Dr. DeMier's diagnosis of delusional disorder was a plausible one, but he did not exclude schizophrenia as an alternative explanation for his symptoms. J.A. 227. Regardless whether petitioner should be diagnosed as schizophrenic or delusional, however, Dr. Wolfson testified that petitioner was "clearly psychotic" and the appropriate course of treatment in either case was medication. J.A. 227, 228.[3] Based on petitioner's conduct at Springfield and his history, Dr. Wolfson believed that petitioner was dangerous in a broadly defined sense. J.A. 232.

Dr. Wolfson testified that he had treated between 1000 and 2000 patients with antipsychotic medication and that most of them had positive results. J.A. 233. He noted that antipsychotic medication had some potential unpleasant side effects, such as dystonic reaction and sedation. J.A. 233-234, 240. Dr. Wolfson stated that such side effects could be mitigated by other medicines or treatments and that "most patients don't have to expect problematic side effects as the cost of having their illness treated and having control of their own thoughts and minds." J.A. 234. Dr. Wolfson testified that neuroleptic malignant syndrome was also a potential serious side effect, which he estimated as occurring

[3] "In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders." DSM IV xxii. Appropriate diagnosis and treatment decisions accordingly are not confined to a specific diagnosis. *Id.* at xxiii ("The specific diagnostic criteria included in the DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion.").

in 1 in 10,000 cases, but he noted that "the risk of the continuing illness [was] greater than the risk of [petitioner] receiving this medicine and developing [the side effect.]" J.A. 236. Dr. Wolfson declined to specify the particular medication that he would prescribe for petitioner because he hoped that petitioner would play a role in choosing the medication. J.A. 238. Dr. Wolfson did indicate that three atypical drugs (quetiapine, olanzapine, and ziprasidone), which have a more "benign side effect" profile, made the "most sense." J.A. 238-239.

Dr. Wolfson stated that he had successfully used antipsychotic medication four out of five times to restore the competency of patients with delusional disorder. J.A. 240, 241, 261-263. Dr. Wolfson opined that he had "a good chance" of restoring petitioner's competency. J.A. 242.

At the hearing, petitioner again proffered the affidavit of Dr. Cloninger. J.A. 212, 300-301. Dr. Wolfson disagreed with Dr. Cloninger's conclusion that antipsychotic medication would provide no benefit to patients with delusional disorder. J.A. 244-248, 274-276. Dr. Wolfson also believed that Dr. Cloninger's proposed course of treatment involving access to exercise, reading material, and anti-depressants was "insufficient" to treat petitioner. J.A. 248. He explained that "[i]f we were having this conversation in 1935, that would be the best I would be able to offer him. But, this is unsupported, perhaps even irresponsible * * * as an adequate way to address [petitioner's] difficulties." *Ibid.*[4]

[4] Petitioner also proffered a report on an unidentified patient diagnosed with delusional disorder by Dr. Daniel Greenstein, a forensic psychologist at the Bureau of Prisons' Metropolitan Correctional Center in Chicago, Illinois. J.A. 212-214, 300-302. In his report, Dr. Greenstein stated that "[d]elusional disorder does not typically respond to pharmacological intervention or psychotherapy." J.A. 214. Dr. Wolfson believed that Dr. Greenstein's statement was "incorrect." *Ibid.*

3. On August 9, 2000, the magistrate judge ordered that petitioner be involuntarily administered antipsychotic medication. J.A. 320-338. He found that petitioner posed "a danger to himself and others at the institution," J.A. 333, that antipsychotic medications were "the only way to render [petitioner] not dangerous and competent to stand trial," J.A. 335, and that there were "no other less restrictive means by which this may be accomplished." *Ibid.*

The district court affirmed the magistrate judge's order. J.A. 339-355. The court concluded that the magistrate judge had clearly erred in finding that "[petitioner] present[ed] a danger to himself or others." J.A. 349. The court found, however, that involuntary medication was justified by the need to restore petitioner to competency. The court concluded "(1) that anti-psychotic drugs are medically appropriate for [petitioner], (2) that they represent the only viable hope of rendering [petitioner] competent to stand trial, and (3) that the administration of such drugs appears necessary to serve the government's compelling interest in obtaining an adjudication of [petitioner's] guilt or innocence of numerous and serious charges." J.A. 354.

4. A divided panel of the court of appeals affirmed. J.A. 356-382. The court upheld the district court's ruling that the evidence did not support a finding that petitioner posed a danger to himself and others at the medical center. J.A. 363. Relying on *Riggins* v. *Nevada*, 504 U.S. 127 (1992), and *Washington* v. *Harper*, 494 U.S. 210 (1990), the court of appeals held that, in order for the government to involuntarily medicate an individual:

> First, the government must present an essential state interest that outweighs the individual's interest in remaining free from medication. * * * Second, the government must prove that there is no less intrusive way of fulfilling its essential interest. * * * Third, the government must prove by clear and convincing evidence that the medication is medically appropriate.

J.A. 367-368 (citations omitted).

The court of appeals held that the government had met its burden under those standards. The court first concluded that "[t]he government has an essential interest in bringing a defendant to trial." J.A. 368. The court noted that "[n]ot all charges, however, are sufficient to justify forcible medication of a defendant; rather, the charges must be serious." *Ibid.* The court decided that the 62 charges of fraud and single count of money laundering were serious enough to outweigh petitioner's significant liberty interest in refusing antipsychotic medication. J.A. 369. The court declined to rely on the government's interest in adjudicating the attempted murder charges relating to the FBI agent and a witness because the court thought it "possible that [petitioner's] threats after his first indictment were a manifestation of his delusional disorder." J.A. 369 n.8.

Second, the court of appeals upheld the district court's finding that there were no less intrusive means by which the government could achieve its essential interest in bringing petitioner to trial. J.A. 369-370. The court observed that "[b]oth Dr. Wolfson and Dr. DeMier testified that antipsychotic medication [was] the most effective treatment for delusional disorder and that it [was] the only way [petitioner] could be restored to competency." J.A. 369. The court also noted that the affidavit from petitioner's psychiatrist, Dr. Cloninger, who disputed the efficacy of the medication, "did not suggest any alternative means of restoring competency." J.A. 370.

Third, the court of appeals found that the government had shown by clear and convincing evidence that there was "a sufficient likelihood that antipsychotic medication [would] restore [petitioner's] competence," J.A. 374; "that the side-

effects produced by the medication could be minimized through careful treatment and changing medications and dosages," *ibid.*; and that the "benefits outweighed the risks associated with antipsychotic drugs." J.A. 375.

The court of appeals next held that the district court had "properly considered [petitioner's] Sixth Amendment right to a fair trial." J.A. 375. The court explained that "before forcibly medicating an accused, there must be evidence that he will be able to participate in a fair trial." J.A. 376. Here, "the medical evidence presented indicated a reasonable probability that [petitioner] will fairly be able to participate in his trial." *Ibid.* Actual effects on competency and demeanor, the court added, may be evaluated after the medication. The court noted that the district court had indicated "its willingness to re-examine [petitioner's] Sixth Amendment claim after the medication regime has begun." *Ibid.*

Judge Bye dissented. J.A. 377-382. Judge Bye would have applied "strict scrutiny" to the review of whether petitioner could be involuntarily medicated to restore his competence. J.A. 377. The dissent also argued that the government had failed to satisfy the first part of the majority's three-part test because "the [fraud and money laundering] charges against [petitioner] are not sufficiently serious." *Ibid.*[5]

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[5] The court of appeals did not discuss whether it had jurisdiction over the district court's interlocutory order. The United States agrees with the courts of appeals that have addressed the issue and have concluded that an order approving the involuntary medication of a pre-trial detainee constitutes an appealable collateral order under *Cohen* v. *Beneficial Industrial Loan Corp.*, 337 U.S. 541, 546 (1949). *United States* v. *Gomes*, 289 F.3d 71, 79 (2d Cir. 2002), petition for cert. pending, No. 02-7118 (filed Oct. 22, 2002); *United States* v. *Morgan*, 193 F.3d 252, 258-259 (4th Cir. 1999); *United States* v. *Brandon*, 158 F.3d 947, 950-951 (6th Cir. 1998); cf. *United States* v. *Weissberger*, 951 F.2d 392, 396 (D.C. Cir. 1991) (court had jurisdiction under *Cohen* to review order permitting involuntary confinement for competency examination under 18 U.S.C. 4241(a)).

SUMMARY OF ARGUMENT

The government has a compelling interest in adjudicating serious criminal charges. At the same time, an incompetent defendant cannot be brought to trial unless his competence can be restored. To permit criminal charges to be resolved, the government therefore has an essential interest in making efforts to restore competence. When, as in this case, the government proposes to restore a defendant's competence through antipsychotic drugs, the defendant's significant liberty interest in avoiding unwanted treatment requires the government to bear the burden of justifying the proposed medical intervention. That burden can be met when there is a substantial probability that medication will restore competence, the medication is medically appropriate, there is no less intrusive alternative, and the defendant, if restored to competence, can be expected to receive a fair trial.

A. The government's interest in prosecuting charges of serious crime is compelling. Felony offenses traditionally have been recognized as serious offenses, whether or not a particular offense involves violence. Many serious offenses, such as treason, espionage, and drug trafficking, are serious even if not violent. Widespread fraudulent schemes also inflict great harm on society and constitute serious offenses.

When involuntary medication is necessary to restore competence, no alternative to that approach would adequately serve the government's interest. Absent restoration of competence, the defendant cannot be tried. It is therefore possible that a defendant may be set free entirely, despite a grand jury indictment charging serious crimes. And the function of a criminal trial publicly to find facts and impose consequences plainly cannot be duplicated by steps such as civil commitment. Civil commitment also imposes unique restraints on the defendant's own liberty interests. Absent treatment, the confinement may continue indefinitely. And during such confinement, the defendant can be ordered

medicated, if necessary for institutional reasons or his own safety, without the safeguards afforded in a criminal case of prior judicial review.

B. The question then becomes whether involuntary medication is likely to restore competence and is medically appropriate. The professional literature, the experience of the Bureau of Prisons, and the record in this case establish that for psychotic disorders, there is a high likelihood that antipsychotic medication will restore competence and that the medication is medically appropriate (and often indispensable) to treat the devastating symptoms of schizophrenia and other diseases. No less restrictive form of intervention is likely to restore competence, and, by itself, no alternative intervention can serve the defendant's medical interests. It is well documented that antipsychotic medication can operate to clear the patient's mind of delusions and hallucinations and restore his capacity for rational thinking, coherent communication, and goal-directed behavior—attributes that are central to competence in a criminal case.

Antipsychotic medication does have side effects, and those effects must be considered in the determination of medical appropriateness—as well as in determining whether the defendant, if restored to competence, will receive a fair trial. But all medications have side effects, and medical appropriateness necessarily turns on a balancing of risks and benefits. In the case of many devastating psychotic diseases, the potential side effects, though serious, are more than amply offset by the likely benefits. Most risks, in addition, can be medically managed—by reducing dosages, changing medications, or prescribing counteracting agents. And the most severe potential side effects are unlikely to emerge in the short-term period during which involuntary medication is necessary for a defendant to prepare for and stand trial.

Equally important, psychiatric medication has progressed dramatically since *Riggins*. A new generation of "atypical"

antipsychotic medications has greatly reduced the most serious side effects. Particularly in light of those advances, medical professionals can reliably attest to the appropriateness and likely success of medication in restoring competence, and courts can reliably make findings that justify ordering such treatment, consistent with the defendant's substantive due process rights.

C. The First Amendment does not preclude the use of involuntary medication to restore competence. The expressive and freedom-of-thought interests that the First Amendment protects are also encompassed by the liberty interests at stake in substantive due process analysis. And antipsychotic medication is likely to enhance, rather than suppress, a psychotic or delusional patient's ability to think and communicate, faculties that have often been shattered by the disease itself.

D. The Fifth and Sixth Amendment rights to a fair trial can be fully protected when a court orders involuntary medication. The opinion of the Court in *Riggins* and Justice Kennedy's concurrence observed that antipsychotic medication can have side effects that can produce trial prejudice. But the experience of many defendants who have been restored to competence after receiving antipsychotic medication reveals that such prejudice is not a necessary consequence of medication. The goal of the medication is to restore competence, and if the defendant cannot stay awake, follow the proceedings, or communicate with counsel, the standard of competence has not been achieved. When competence is achieved, it is reasonable to expect that side effects—such as impairments of a defendant's demeanor or sedation—can be medically managed and controlled. The concrete evaluation of what side effects materialize, and whether they can be controlled to avoid an unfair trial, thus should be made after medication has restored competence. In addition, careful management of the trial itself, as well as

testimony and jury instructions explaining any effects of the medication, can further reduce any risk of prejudice.

Finally, a defendant has no constitutional right to appear before the jury in an unmedicated, psychotic state in order to bolster a mental-status defense. A trial of a defendant in such state is unlikely to occur, since the defendant probably would not be competent. And a mentally ill defendant has no right to appear before the jury in the purported mental state that he possessed on the occasion of the crime. Proof of his mental state can be made by the normal means: medical reports, eyewitness testimony, expert testimony, and the defendant's own recollections. Those means are adequate to enable the defendant to make his defense.

E. Applying those standards, the courts below correctly found that an order of antipsychotic medication of petitioner is justified. The felony fraud charges against him are serious; antipsychotic medication, and no less intrusive alternative, is likely to restore petitioner's competence; such medication is medically appropriate; and there is every reason to believe that he will receive a fair trial if restored to competence.

ARGUMENT

THE DISTRICT COURT'S ORDER THAT PETITIONER BE INVOLUNTARILY MEDICATED TO RESTORE HIS COMPETENCE IS CONSTITUTIONAL

A defendant is incompetent to stand trial when he cannot understand the nature of the criminal proceedings and cannot cooperate with counsel in his defense. *E.g.*, *Cooper* v. *Oklahoma*, 517 U.S. 348, 354 (1996). When a defendant's incompetency precludes the adjudication of serious criminal charges, there is a compelling governmental interest in taking reasonable measures to restore a defendant's competency. Often, as in this case, attainment of that interest requires the administration of antipsychotic medication.

When the defendant resists, such a step implicates his significant liberty interest in avoiding unwanted medication, as well as his right to a fair trial. Those interests are properly reconciled by requiring the government to show, before involuntarily medicating a defendant, that: (1) the administration of antipsychotic drugs has a substantial probability of restoring the defendant's competency; (2) the medication is medically appropriate; (3) no less intrusive measures will serve the government's interest in restoring competence; and (4) it is reasonable to expect that the defendant, if restored to competence, will be able to receive a fair trial. On the facts of this case, all of those factors were established.

I. THE INVOLUNTARY ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION TO RESTORE A DEFENDANT'S COMPETENCE TO STAND TRIAL ON SERIOUS CHARGES CAN BE ORDERED CONSISTENT WITH THE DEFENDANT'S SUBSTANTIVE DUE PROCESS RIGHTS

"So-called 'substantive due process' prevents the government from engaging in conduct that 'shocks the conscience,' or interferes with rights 'implicit in the concept of ordered liberty.'" *United States* v. *Salerno*, 481 U.S. 739, 746 (1987) (quoting *Rochin* v. *California*, 342 U.S. 165, 172 (1952) and *Palko* v. *Connecticut*, 302 U.S. 319, 325-326 (1937)). "[I]dentifying the contours" of substantive due process "involves a definition of the protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it." *Harper*, 494 U.S. at 220 (quoting *Mills* v. *Rogers*, 457 U.S. 291, 299 (1982)). This Court has made clear that an individual has a significant liberty interest in avoiding the involuntary administration of antipsychotic medication. *Riggins*, 504 U.S. at 134; cf. *Cruzan* v. *Director, Mo. Dep't of Health*, 497 U.S. 261 (1990). Such an interest, however, is "not absolute," because not

every infringement of a liberty interest violates the Constitution. *Youngberg* v. *Romeo*, 457 U.S. 307, 320 (1992). An "individual's strong interest in liberty," even though "importan[t] and fundamental," may, "in circumstances where the government's interest is sufficiently weighty, be subordinated to the greater needs of society." *Salerno*, 481 U.S. at 750-751.

A. Substantive Due Process Analysis Requires Balancing The Government's Interests Against The Liberty Interest Of The Defendant

In *Harper*, 494 U.S. at 227, this Court held that substantive due process does not bar the government from involuntarily medicating a convicted prisoner who is dangerous to himself or others, when the medication is medically appropriate. In so holding, the Court weighed the government's interest in prison "safety and security" against the defendant's substantive liberty interest, and concluded that the proper standard of review asked whether the proposed intrusion was "reasonably related to legitimate penological interests." *Id.* at 223 (quoting *Turner* v. *Safely*, 482 U.S. 78, 89 (1987)).

In *Riggins*, 504 U.S. at 135, the Court considered a claim that the involuntary medication of a defendant with an antipsychotic drug (Mellaril) violated the defendant's Sixth and Fourteenth Amendment rights because it created a risk of trial prejudice and because the State had failed "to establish the need" for the medication. The Court held that "since the District Court allowed administration of Mellaril to continue without making *any* determination of the need for this course or *any* findings about reasonable alternatives," *id.* at 135-136, the creation of possible trial prejudice to the defendant was unjustified. *Id.* at 137-138. The Court observed that, although "trial prejudice can sometimes be justified by an essential state interest," the record in the

case contained "no finding that might support a conclusion that administration of antipsychotic medication was necessary to accomplish an essential state policy." *Id.* at 138. The Court stated, however, that "the State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of [the defendant's] guilt or innocence by using less intrusive means." *Id.* at 135.

The Court in *Riggins* stated that it had not adopted "a standard of strict scrutiny," explaining that it had no "occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings." 504 U.S. at 136. As in other cases involving substantive due process, however, the determination of whether, and under what circumstances, the government may justify involuntary treatment with antipsychotic medication in order to restore a defendant's competence requires careful examination of the competing interests. In a variety of analogous contexts this Court's substantive due process jurisprudence has applied such a balancing test, weighing the competing interests in order to determine when an intrusion on a significant liberty interest is justified. In *Youngberg* v. *Romeo*, 457 U.S. at 320-322, for example, the Court determined that the liberty interest of involuntarily-committed mentally disabled persons to enjoy freedom of movement within the institution may be restricted based on an exercise of the institution's professional judgment. See also *Bell* v. *Wolfish*, 441 U.S. 520, 537-538 (1979) (upholding the constitutionality of restrictions on pre-trial detainees' liberty). The Court has similarly balanced the competing interests in order to determine when the government may override a defendant's liberty interest and detain him pre-trial based on threats of future dangerousness, *Salerno*, 481 U.S. at 746-751; when a defendant found incompetent to stand trial may be thereafter confined; *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972);

and when a defendant found not guilty by reason of insanity may be subject to involuntary commitment, *Foucha* v. *Louisiana*, 504 U.S. 71, 79 (1992); *Jones* v. *United States*, 463 U.S. 354, 368 (1983).

The same approach is warranted here. In developing a substantive standard for when involuntary medication is permissible, the critical factors are the importance of the government's interest in adjudicating serious criminal charges, the lack of adequate alternatives to involuntary medication, the consequences for the defendant's liberty interests of administering or (not administering) medication, and the ability of a medicated defendant to receive a fair trial. Consideration of those factors leads to the conclusion that the government's interest in adjudicating serious offenses is sufficiently important to outweigh an individual's liberty interest in refusing unwanted antipsychotic medication, when the government can demonstrate that the medication has a substantial probability of restoring competence and is medically appropriate; that there is no reasonable and less intrusive alternative; and that it is reasonable to expect that the defendant, if restored to competency, will receive a fair trial.[6]

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[6] The majority of the courts of appeals have concluded that the appropriate form of review involves "heightened" but not "strict scrutiny." J.A. 366-367 n.7; *Gomes*, 289 F.3d at 82; *United States* v. *Weston*, 255 F.3d 873, 880 (D.C. Cir.), cert. denied, 122 S. Ct. 670 (2001); but see *United States* v. *Brandon*, 158 F.3d at 956-961. That conclusion is correct. Petitioner urges the Court to apply "strict" scrutiny (Br. 35-36), but this Court's substantive due process decisions do not require that conclusion. A defendant's wish to remain incompetent in a criminal case by refusing medically appropriate and necessary medication should not be regarded as a fundamental right that triggers strict scrutiny. Cf. *Washington* v. *Glucksberg*, 521 U.S. 702, 720-721 (1997) (requiring a "careful description" of the asserted interest to determine whether it is, "objectively, 'deeply rooted in this Nation's history and tradition.'") (citations omitted). In the present context (and regardless of the name attached to the form of judicial review), the test should not be set so unrealistically high that medically

B. The Government Has An Overriding Interest In Adjudicating Serious Criminal Charges

The government has a compelling interest in bringing a defendant to trial after probable cause has been found to justify prosecution for a serious criminal offense. As this Court noted in *Riggins*, the "[c]onstitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and prerequisite to social justice and peace." 504 U.S. at 135-136 (quoting *Illinois* v. *Allen*, 397 U.S. 337, 347 (1970) (Brennan, J., concurring)); see also *Winston* v. *Lee*, 470 U.S. 753, 762 (1985) (noting that "the community's interest in fairly and accurately determining guilt or innocence" is "of great importance"). The Court has repeatedly referred to the government's "compelling interest in finding, convicting, and punishing those who violate the law." *Moran* v. *Burbine*, 475 U.S. 412, 426 (1986); accord *Texas* v. *Cobb*, 532 U.S. 162, 172 (2001); *McNeil* v. *Wisconsin*, 501 U.S. 171, 181 (1991); *Richardson* v. *Marsh*, 481 U.S. 200, 210 (1987); *Garrett* v. *United States*, 471 U.S. 773, 796 (1985) (O'Connor, J., concurring). "The sole constitutional mechanism for the government to accomplish its essential policy is to take [a defendant] to trial." *United States* v. *Weston*, 255 F.3d 873, 882 (D.C. Cir.) (citing U.S. Const. Amend. V)), cert. denied, 122 S. Ct. 670 (2001). Accordingly, the government's interest extends to "ensuring that persons accused of crimes are

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responsible steps to restore competence are automatically foreclosed. Nor should the government's interest in adjudicating guilt on serious criminal charges be wholly subordinated to an individual's liberty interests. To the contrary, this Court's decisions have recognized that even significant liberty interests may be subject to overriding societal interests. *E.g.*, *Salerno*, 481 U.S. at 750-751 (pre-trial detention for a "serious" crime based on proof of dangerousness); *Addington* v. *Texas*, 441 U.S. 418, 430-431 (1979) (civil commitment based on "clear and convincing" evidence; rejecting a beyond-a-reasonable-doubt standard that would foreclose civil commitment "for many patients desperately in need of institutionalized psychiatric care").

available for trials and, ultimately, for service of their sentences." *Bell* v. *Wolfish*, 441 U.S. at 534.

Petitioner errs in asserting (Br. 35, 36, 42) that this Court's decisions bar the government from seeking an order of involuntary medication for "prosecutorial" purposes. Certain extreme intrusions on a suspect's bodily integrity are unjustified in order to investigate crime or gather evidence. *Rochin*, 342 U.S. at 172 (stomach pumping is "too close to the rack and the screw to permit of constitutional differentiation"). Here, however, the interest at stake is society's essential concern that serious criminal charges, brought by a grand jury, receive a fair determination in open court. Even with respect to evidence gathering, there is no absolute rule against medical intrusions. *Schmerber* v. *California*, 384 U.S. 757 (1966) (taking of blood sample permitted). There is even less warrant for an absolute rule that would prevent medically appropriate efforts to obtain a fair adjudication of criminal charges through antipsychotic medication that restores a defendant's competence.

The government's interest is not diminished by the fact that a pre-trial detainee is "presumed to be innocent" until convicted of a crime. Pet. Br. 23, 24, 25, 36. This Court has explained that "[t]he presumption of innocence is a doctrine that allocates the burden of proof in criminal trials; it also may serve as an admonishment to the jury to judge an accused's guilt or innocence solely on the evidence adduced at trial." *Bell*, 441 U.S. at 533. The presumption of innocence, however, "has no application to a determination of the [substantive due process] rights of a pretrial detainee during confinement before his trial has even begun." *Ibid.*

1. The government's interest in adjudicating guilt on a serious offense is not limited to violent offenses

Petitioner and some of his amici argue that the government's interest is not sufficiently weighty when the

defendant wishes to remain incompetent to stand trial on charges that do not involve "violence." Pet. Br. 35-38, 41-43; Rutherford Am. Br. 17-18; ACLU Am. Br. 1-19. There is no sound basis for that limitation. The government has an unquestioned vital interest in prosecuting and punishing violent crime. But other breaches of the public order likewise demand judicial resolution. Petitioner is charged with the commission of felony offenses, and, as such, those charges are sufficiently serious to justify the administration of medication to restore competence.[7]

First, the government has a compelling interest in adjudicating an individual's guilt or innocence of felony charges. Felonies represent a traditional category of serious offenses, whether or not the offense involves violence. See *Nichols* v. *United States*, 511 U.S. 738, 743 n.9 (1994) (right to counsel under *Gideon* v. *Wainwright*, 372 U.S. 335 (1963), applies to all felony offenses). Indeed, there are many serious offenses, such as treason, espionage, acts of economic terrorism, and drug trafficking, that may be committed without resort to violence. Cf. *Salerno*, 481 U.S. at 750 (Bail Reform Act focused on a narrow category of "extremely serious offenses," including drug trafficking). Violence may also be absent in offenses that involve major economic losses, such as large-scale fraud cases for which the government seeks

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[7] The court of appeals held that it would not consider that petitioner is charged with violent offenses (conspiracy to murder an FBI agent and a witness) because, in the court's view, "[i]t is possible that [petitioner's] threats after his first indictment were a manifestation of his delusional disorder." J.A. 369 n.8. This Court's formulation of the question presented presupposes that the defendant was charged with non-violent offenses. J.A. 334. But the possibility that a defendant's violent crimes were a "manifestation" of his mental illness should not preclude the government from involuntarily medicating him in order to go to trial on those charges. The government's interest in obtaining an adjudication on serious criminal charges is not diminished because of the possibility that the defendant's mental disease *may* afford a defense; it is the purpose of the trial to see if it does.

restitution for numerous victims. The government's interest in prosecuting those offenses is not invariably less compelling than its interest in prosecuting violent offenses.

Second, limiting the government's interest to offenses that are inherently violent overlooks that many defendants who commit nonviolent crimes may also commit violent criminal acts to avoid apprehension or conviction. "The fact that a person has been found * * * to have committed a criminal act certainly indicates dangerousness." *Jones*, 463 U.S. at 364. There is a significant risk, for example, that persons charged with crimes of pure theft will resort to violence in response to, or to thwart, law enforcement. "[C]rimes of theft frequently may result in violence from the efforts of the criminal to escape or the victim to protect property or the police to apprehend the fleeing criminal." *Id.* at 365 n.14. This case similarly illustrates the point. After petitioner was indicted on the fraud and money laundering charges, he allegedly arranged to have murdered both the FBI agent who arrested him and a former employee at his dental office. The employee was allegedly targeted in retaliation for her cooperation with law enforcement and to prevent her from testifying against petitioner on the fraud charges. J.A. 23-29, 358.

Third, limiting the government's essential interest in adjudicating criminal charges to offenses involving violence would create difficult line-drawing problems. Under some definitions, offenses involving physical force against property constitute crimes of violence, while under other definitions, violent crimes are limited to offenses against persons. Compare 18 U.S.C. 16 ("crime of violence" includes offenses involving risk of "physical force against the person *or property* of another") (emphasis added), with 18 U.S.C. 924(e)(2)(B) ("violent felony" includes offenses that present risk "of physical injury to another"); cf. 18 U.S.C. 4246 (allowing involuntary commitment if person presents a "substantial risk of * * * *serious damage to property of another*) (emphasis added). Courts would also have to decide whether certain state law offenses, such as burglary, are violent offenses because of the potential risk of violence to persons, and whether such a determination is made according to the statutory elements or the facts underlying the charge. Cf. *Taylor* v. *United States*, 495 U.S. 575 (1990). Similar questions would arise for federal offenses such as the offense of unlawful possession of a firearm by a felon, in violation of 18 U.S.C. 922(g)(1). *E.g*, *United States* v. *Gomes*, 289 F.3d 71, 86 (2d Cir. 2002) (finding government had essential interest in adjudicating felon-in-possession offense), petition for cert. pending No. 02-7118 (filed Oct. 22, 2002); cf. *Stinson* v. *United States*, 508 U.S. 36, 39 & n.1 (1993) (discussing amendment to Sentencing Guidelines excluding felon-in-possession offenses from a career-offender predicate "crime of violence").

Fourth, the charged fraud offenses in this case illustrate why the government's interest in adjudicating non-violent felony offenses is weighty. The Court has in other contexts recognized that the government's interest in preventing fraud is "important" (*Watchtower Bible & Tract Soc'y of New York, Inc.* v. *Village of Stratton*, 122 S. Ct. 2080, 2089 (2002)), and "substantial" (*Village of Schaumburg* v. *Citizens for a Better Env't*, 444 U.S. 620, 636 (1980)). Accord *Riley* v. *National Fed'n of the Blind*, 487 U.S. 781, 792 (1988) (interest in protecting the public against fraud "is, of course, a sufficiently substantial interest to justify a narrowly tailored regulation").

Here, petitioner was charged with 56 counts of health care fraud, six counts of Medicaid fraud, and one count of money laundering based on a pervasive scheme to submit hundreds of false claims to Medicaid and private insurance companies between 1989 and 1997. The indictment alleges that petitioner, and employees at his direction, submitted manufac-

tured x-ray images and other altered dental records to Medicaid and private insurance companies to reflect dental problems that did not exist and dental services that were not performed. Those crimes harmed society by draining an important federal assistance program of its limited resources. The court of appeals correctly concluded that those charges were sufficiently serious to outweigh petitioner's liberty interest in avoiding forced medication. J.A. 368-369.

2. The alternatives to bringing petitioner to trial are inadequate to serve the government's interest

The Due Process Clause prohibits the criminal prosecution of a defendant who is not competent to stand trial. *Cooper*, 517 U.S. at 354; *Godinez* v. *Moran*, 509 U.S. 389, 396 (1993); *Medina* v. *California*, 505 U.S. 437, 439 (1992); *Drope* v. *Missouri*, 420 U.S. 162, 171 (1975); *Pate* v. *Robinson*, 383 U.S. 375 (1966). Thus, the recognition of a constitutional right to refuse medication necessary to restore competency to stand trial results, most immediately, in the inability of society to obtain a prompt resolution of pending criminal charges. In lieu of trial, the individual will either be released or involuntarily committed pursuant to 18 U.S.C. 4246. Neither alternative adequately vindicates the government's interest.

The government's "compelling interest in finding, convicting, and punishing those who violate the law" (*Moran* v. *Burbine*, 475 U.S. at 426) would be seriously undermined if an incompetent defendant cannot be brought to trial because of his decision to refuse medication necessary to restore competence. The possibility that the defendant will spontaneously regain competence without needed medication is remote at best. And even if the defendant at some later time receives treatment for his condition and his competency is restored, that event may occur too late for a successful prosecution. A defendant whose competence cannot be

restored may thereby achieve immunity from liability for his criminal acts.

Nor does the possibility of civil commitment adequately serve the governmental interests at stake. Under 18 U.S.C. 4241(d), a pre-trial detainee whose "mental condition has not so improved as to permit the trial to proceed * * * is subject to the provisions of section 4246." Under Section 4246(d), if the court following a hearing finds by clear and convincing evidence that "the person is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another," the person must remain in the custody of the Attorney General for "treatment" unless a State will assume responsibility for him and his mental condition. *Ibid.*

As with a defendant who is released, the passage of time and the fading memories of witnesses may ultimately preclude the government from prosecuting the charges against a civilly committed defendant, even if he were to regain competence while involuntarily hospitalized. At a minimum, indefinite delay harms "[s]ociety's particular interest in bringing swift prosecutions," *Barker* v. *Wingo*, 407 U.S. 514, 527 (1972), not only because "[a]s the time between the commission of the crime and trial lengthens, witnesses may become unavailable or their memories may fade," *id.* at 521, but the delay prevents an adjudication that brings closure for the victims of the offense. And "even though civil commitment might reduce the danger to the community posed by an individual, it cannot address a host of other important societal concerns and values served by a criminal trial: 'the retributive, deterrent, communicative and investigative functions of the criminal justice system * * * serve to ensure that offenders receive their just deserts, to make clear that offenses entail consequences, and to discover what

happened through the public mechanism of trial.'" *Gomes*, 289 F.3d at 81 (quoting *Weston*, 255 F.3d at 882).

Involuntary commitment also does not well serve the liberty interest of the defendant who could face indefinite hospitalization in a federal prison hospital pursuant to 18 U.S.C. 4246. Absent medication, the person could simply be "warehoused" indefinitely, languishing without effective treatment for a serious mental disease, for periods well in excess of any sentence he may have served had he been found guilty of crimes for which he was charged. And a defendant who is hospitalized may in any event be medicated against his will under the standards of *Harper*. Bureau of Prisons' regulations authorize the forcible administration of medically appropriate antipsychotic medication if a psychiatrist, following an administrative hearing, determines that the inmate "is dangerous to self or others, is gravely disabled, or is unable to function in the open population of a mental health referral center or a regular prison." 28 C.F.R. 549.43(a)(5); cf. *Jurasek* v. *Utah State Hosp.*, 158 F.3d 506 (10th Cir. 1998) (applying *Harper* to permit forcible medication of patient involuntarily confined in state hospital upon showing that patient is dangerous to self or others or is gravely ill). In that situation, contrary to petitioner's assertion (Br. 38), an involuntarily committed patient will have *less* procedural protections than a pre-trial detainee, like petitioner, whom the government seeks to medicate to restore competency. Cf. *Harper*, 494 U.S. at 229-236 (judicial order not required to involuntarily medicate convicted prisoner).

C. Involuntary Medication Is Justified When There Is A Substantial Probability Of Restoring Competence And When Medically Appropriate

Because of the significant liberty interest of the defendant, the government must show that involuntary administration of antipsychotic medication is substantially likely to render the defendant competent to stand trial. Under this Court's decision in *Harper*, moreover, any involuntary administration of antipsychotic drugs must be medically appropriate. 494 U.S. at 227.

1. Antipsychotic medication, and no less-intrusive alternative, is substantially likely to restore competence

In *Jackson*, 406 U.S. at 738, this Court held that "a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future." Cf. 18 U.S.C. 4241(d) (requiring Attorney General to "hospitalize [an incompetent] defendant for treatment * * * to determine whether there is a substantial probability that in the foreseeable future he will attain the capacity to permit the trial to proceed."). Just as the Constitution permits temporary and involuntary confinement based on a substantial probability of restoring competence, the Constitution likewise permits the temporary and involuntary administration of medically appropriate antipsychotic drugs when such treatment is substantially probable to restore competency.

As an empirical matter, medication with antipsychotic drugs is substantially likely to render a psychotic defendant competent to stand trial. The experience of the Bureau of Prisons is that antipsychotic medication is highly effective in restoring competency. Over a recent twelve-month period, the Bureau evaluated and treated 285 patients who were deemed under 18 U.S.C. 4241(d) to be incompetent to stand trial. Of the 226 persons who voluntarily accepted treatment, which in almost all instances included medication, 197 or 87.2% were restored to competency. Of the 59 persons

who were involuntarily medicated following an administrative hearing under the Bureau's regulations, 45 or 76.3% were restored to competency. That success rate is consistent with "[s]tudies [that] have concluded that the vast majority of incompetent defendants who are involuntarily committed for treatment are successfully restored to competence." American Psychological Ass'n Am. Br. 19.[8]

Petitioner suggests (Br. 38-40) that the government must show with "certainty" that medication will restore a defendant's competency to stand trial. Even when the government seeks to deprive a person of liberty by convicting him of a crime and punishing him, however, certainty is not required. See *Addington* v. *Texas*, 441 U.S. 418, 430 (1979) (beyond-a-reasonable-doubt standard does not require certainty beyond *any* doubt). And as the D.C. Circuit in *Weston* has explained, "[e]ven narrow tailoring in strict scrutiny analysis does not contemplate a perfect correspondence between the means chosen to accomplish a compelling governmental interest." 255 F.3d at 883. A requirement of certainty or near certainty overlooks the practical reality that neither physicians nor courts can make that sort of predictive medical judgment. *Addington*, 441 U.S. at 430 ("The subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations."); cf.

[8] A study of 61 defendants who were involuntarily treated to restore competency to face charges in New York found that 87% of the treated individuals were restored to competency and 93% were clinically improved. See B. Ladds et al., *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review*, 21 Bull. of the Am. Acad. Psychiatry Law 529, 529-545 (1993); B. Ladds et al., *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial*, 38 J. Forensic Sci. 1442, 1442-1459 (1993). A similar study of 205 defendants found incompetent to face charges under California law reports a 90% success rate from anti-psychotic medication. L. Pendelton, *Treatment of Persons Found Incompetent to Stand Trial*, 137 Am. J. Psychiatry 1098, 1098-1100 (1980).

Daubert v. *Merrell Dow Pharms. Inc.*, 509 U.S. 579, 590 (1993) ("Of course, it would be unreasonable to conclude that the subject of scientific testimony must be 'known' to a certainty; arguably, there are no certainties in science."). "The small possibility that antipsychotic medication will not make [a defendant] competent for trial is certainly tolerable considering that antipsychotic medication is the sole means for the government to satisfy its essential policy." *Weston*, 255 F.3d at 883.

In addition to showing a substantial likelihood that medication will render a defendant competent to stand trial, the government must show that no reasonable less-intrusive alternative to medication will accomplish the government's objective. For the vast majority of individuals with psychotic illnesses, there are no less intrusive methods of restoring competency. *Riggins*, 504 U.S. at 141 (Kennedy, J., concurring) ("For many patients, no effective alternative exists for treatment of their illnesses."). Indeed, neither petitioner nor the amici suggest that there are viable, less intrusive means to treat most psychotic disorders that result in the individual being incompetent to stand trial. Cf. American Psychological Ass'n Am. Br. 3, 12 (noting that non-drug therapies "are often not adequate by themselves to treat acute psychotic disorders" and that courts should "not force the government to put the defendant through a pointless exercise" of administering alternative treatments to medication).

2. Antipsychotic medication is medically appropriate

It is settled that antipsychotic drugs are medically appropriate for the treatment of psychosis. *Harper*, 494 U.S. at 229 ("the therapeutic benefits of antipsychotic drugs are well documented"); American Psychiatric Press, *Textbook of Psychopharmacology* Ch. 17, at 315 (A.F. Schatzberg & C.B.

Nemeroff eds., 2d ed. 1998) (*Textbook of Psychopharmacology*) ("Antipsychotic medications are effective for nearly every medical and psychiatric condition that results in psychosis."); accord National Institute of Mental Health, *Mental Health: A Report of the Surgeon General* 279-280 (1999) (*Mental Health*); American Psychiatric Ass'n Am. Br. 13-14; American Psychological Ass'n Am. Br. 3, 11.

a. Petitioner's characterization (Br. 18, 23, 32, 33, 42-43) of antipsychotic drugs as "artificially" "mind-altering" and producing a "synthetic sanity" reflects a misunderstanding of the nature and effects of both psychosis and antipsychotic drugs. Psychotic diseases such as schizophrenia and delusional disorders are serious and often debilitating diseases. For instance, "[s]chizophrenia is characterized by profound disruption in cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, affect, and sense of self." *Mental Health* 269 (emphasis omitted). Similarly, delusions "seriously restrict" the "autonomy that comes from logical, realistic, self-serving thinking." A.R. Felthous, M.D. et al., *Are Persecutory Delusions Amenable to Treatment?*, 29 J. Am. Acad. Psychiatry Law 461, 462 (2001); see also A.A. Stone, M.D., *Commentary on Formulating Mental Health Codes for the World*, Psychiatric Times, July 2002, at 4 ("[D]elusions and hallucinations are not a manifestation of human autonomy; they are symptoms of a serious malfunction of the human brain.").

Antipsychotic drugs treat psychotic symptoms that interfere with a person's ability to think and communicate. Antipsychotic drugs "*restore normal* thought processes by clearing hallucinations and delusions." *Riggins*, 504 U.S. at 141 (Kennedy, J., concurring) (emphasis added). "The mental health produced by antipsychotic medication is no different from, no more inauthentic or alien to the patient than, the physical health produced by other medications,

such as penicillin for pneumonia." *Ibid.* (quoting American Psychiatric Ass'n Am. Br. 9). Thus, "[r]ather than mind restricting, the medication is mind liberating. It brings the possibility of a less tortured existence and improved functioning, and it can serve as the key to real, physical liberty * * * in the long run." A.R. Felthous, *supra*, 466; accord T.G. Gutheil, M.D. & P.S. Appelbaum, M.D. *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 Hofstra L. Rev. 77, 118-119 (1983) ("[E]mpirical studies of antipsychotic drug effects on complex cognitive functions * * * overwhelmingly show a positive effect of the medications * * * [not] consistent with a view of these drugs as mind-altering, thought-inhibiting, or destructive of personality in a negative sense. In fact, * * * the medications reinforce the most important aspects of mental functioning.").

Conversely, refraining from treatment has the potential to engender permanent harm, by slowing the response to medication once it is initiated or diminishing the extent of response to the medication. *Mental Health* 274; J.A. 165, 216. "Without medicine," the patient also could remain "deluded and dangerous," and therefore subject to involuntary commitment of a lifelong duration. A.R. Felthous, *supra*, 461; pp. 25-26, *supra*.

Those considerations are particularly acute when the psychotic individual faces criminal charges. The loss of cognitive abilities and rational thinking deprives the individual of any chance of exercising control and autonomy in determining whether to accept responsibility for any criminal conduct, to fight the charges and assist counsel in his defense, or to play a meaningful role in a course of treatment while serving a sentence.

b. Any consideration of medical appropriateness must consider the potential side effects of antipsychotic drugs in

a given case. There are two types of such drugs, the older-generation of conventional or typical drugs, which include chlorpropromazine (Thorazine), thioridazine (Mellaril), haloperidol (Haldol), thiothixene (Navane), and pimozide (Orap), and newer "atypical" drugs, which include clozapine (Clorazil), risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), and aripiprazole (Abilify). 2 *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*, 2356-2377, 2455-2472 (B.J. Sadock & V.A. Sadock eds., 7th ed. 2000) (*Kaplan & Sadock*); *Textbook of Psychopharmacology* 309-321, 323-348. Conventional anti-psychotic drugs can be associated with extrapyramidal (muscular movement) side effects that include parkinsonism (tremor of the limbs, diminished range of facial expression, slowed functions), acute dystonia (severe involuntary spasms of the upper body, tongue, throat or eyes); akathesia (motor restlessness, often characterized by an inability to sit still); neuroleptic malignant syndrome (a very rare condition which can lead to death from cardiac dysfunction); and tardive dyskinesia (a neurological disorder characterized by involuntary, uncontrollable movements of various muscles, especially around the face). *Riggins*, 504 U.S. at 142-144 (Kennedy, J., concurring); *Harper*, 494 U.S. at 229-230; *Mills*, 457 U.S. at 293 n.1. Given the possible side effects from all medications, including anti-psychotic medications, the Bureau of Prisons requires its psychiatrists "to maintain patients on the lowest effective dose of medication." Federal Bureau of Prisons, U.S. Dep't of Justice, *Health Services Manual* Ch. IX, at 6 (Sept. 1996) (*BOP Health Services Manual*). The Bureau also requires that "[a]ll patients on psychiatric medications shall be monitored regularly for side effects; this must be documented in the health record. Particularly for patients maintained on psychiatric medications known to cause tardive dyskinesia, regular monitoring

shall be documented for the development of symptoms of this disease." *Ibid.*

The professional judgment of medical experts is that most side effects of conventional drugs can be monitored and controlled by altering the doses of a drug or changing or adding drugs, and most side effects cease when the drugs are discontinued. *Mental Health* 281; T.G. Gutheil, *supra*, 109; *Textbook of Psychopharmacology* 317; American Psychiatric Ass'n Am. Br. 11, 14-16. As the Second Circuit noted in *Gomes*, "the most harmful side effects associated with conventional antipsychotic medications are rare, result from years of usage, and, to the extent that they arise shortly after administration of the medication, are manageable." 289 F.3d at 84; *Weston*, 255 F.3d at 877. For instance, tardive dyskinesia "virtually never develops after only a few weeks or months of taking the antipsychotic drugs." J. Gorman, *The Essential Guide to Psychiatric Drugs* 219 (3d ed. 1997); see also T.G. Gutheil, *supra*, at 109 ("[T]ardive dyskinesia is generally mild, not necessarily progressive and very often disappears if antipsychotic medication can be halted."). There would therefore normally be virtually no heightened risk of tardive dyskinesia in the temporary administration of drugs in order to restore competence. The risk of side effects associated with the involuntary administration of medication is confined to the limited period necessary to restore the defendant's competence through the course of the legal proceedings. *Gomes*, 289 F.3d at 84.

Significantly, since *Riggins* was decided, medical science has dramatically advanced to produce 'atypical" drugs that treat psychoses with lower risks of the conventional drugs' side effects. *Gomes*, 289 F.3d at 83; *Weston*, 255 F.3d at 886 n.7. Although atypical drugs have their own side effects, such as "sedation, weight gain, sexual dysfunction, and other dose-related discomforts" (*Mental Health* 282), "the side-effect profiles are significantly improved from the older

generation, and the improvements include what strongly appears, from an accumulating body of evidence, to be a substantial reduction of the risk of tardive dyskinesia." American Psychiatric Ass'n Am. Br. 18; S. Caroff et al., *Movement Disorders Associated with Atypical Antipsychotic Drugs*, 63 J. Clin. Psychiatry 12, 16-17 (2002) (concluding that "all of the atypical antipsychotic drugs show a significantly reduced potential in causing acute EPS [extrapyramidal side effects] and other movement disorders" and that "[t]here is fairly consistent and convincing evidence that the atypical antipsychotics have a significantly reduced liability for TD [tardive dyskinesia]"); accord *Mental Health* 280-281; American Psychological Ass'n Am. Br. 22-25. As with the conventional drugs, it is also possible to manage the side effects, including sedation, of the new generation of drugs to minimize and counteract those effects.[9]

There is also little doubt that medical science will continue to develop new drugs that will increase the range of options and decrease the negative side effects. For example, when this case was decided in the lower courts, the new generation, atypical drugs were available only for oral administration and, therefore, could not be used to involuntarily medicate an uncooperative patient. J.A. 235-238 (testimony of Dr. Wolfson). Faced with the choice of conventional or

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[9] Significantly, sedation-type effects may decline as the patient acclimates to the medication. *Mental Health* 281 ("Many other side effects such as attention and vigilance problems, sleepiness, blurry vision, dry mouth, and constipation are worse in the initial weeks of treatment and usually taper off as a person adjusts to the medication."); American Psychiatric Ass'n, *Practice Guidelines for the Treatment of Psychiatric Disorders* 320 (2000) ("Sedation is most pronounced in the initial phases of treatment. Most patients develop some tolerance to the sedating effects with continued administration."). Sedation can also be reduced by medical management. *Ibid.* ("Lowering of the daily dose, consolidation of divided doses into one evening dose, or changing to a less sedating antipsychotic medication can be helpful.").

atypical medications, a defendant who is ordered to take antipsychotic medication may well decide to cooperate in taking one of the atypical drugs in an oral form. *Weston*, 255 F.3d at 886 n.7 (noting defendant's indication that "he would comply with court-ordered medication"); see also P.A. Nidich & J. Collins, *Involuntary Administration of Psychotropic Medication: A Federal Court Update*, 11 Health Lawyer 12, 14 n.21 (May 1999) (The "short-term usage of typical antipsychotics to stabilize a patient to allow him a choice of switching to one of the atypicals presents little risk of serious side effects and is consistent with the standard of care."). Moreover, the Food and Drug Administration (FDA) has now approved for intramuscular injection one atypical drug, ziprasidone (Geodon). See http://www.pfizer.com/hml/pi's/geodonpi.pdf. Other atypical drugs may be available in an injectable form in the future. S. Vedantam, *Implants May Reshape Schizophrenia Treatment*, Washington Post, Nov. 16, 2002 <http://www.schizophrenia-help.com> ("[T]he maker of risperidone, the country's most frequently prescribed atypical antipsychotic, is applying to the [FDA] to market an injectable version" that has been approved for use in the United Kingdom, Germany, Austria, New Zealand, Mexico, the Netherlands, and Switzerland.); *Company News: Eli Lilly & Co. Article*, N.Y. Times, Mar. 9, 2001 <http://premium.news.yahoo.com> (noting application for approval of an injectable form of Zyprexa).

c. "Whether a proposed course of action is 'medically appropriate' obviously depends on the judgment of medical professionals." *Weston*, 255 F.3d at 876. Thus, the question whether the risk of medication will outweigh the medical benefits to the patient will involve a case-specific inquiry in light of the patient's history, medical condition, and state of medical knowledge at the time of medication. Courts making such an inquiry should accord proper "deference * * * to medical professionals who have the full-time responsibility of

caring for mentally ill inmates * * * and who possess, as courts do not, the requisite knowledge and expertise to determine whether the drugs should be used in an individual case." *Harper*, 494 U.S. at 230-231 n.12; see also *Parham* v. *J.R.*, 442 U.S. 584, 607 (1979) ("neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments") (citation omitted). In particular, "[t]he risks associated with antipsychotic drugs are for the most part medical ones, best assessed by medical professionals" who are presumed to act with the best interest of the patient in mind. *Harper*, 494 U.S. at 233.[10]

II. THE INVOLUNTARY ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION THAT ACCORDS WITH SUBSTANTIVE DUE PROCESS DOES NOT VIOLATE THE FIRST AMENDMENT

Petitioner and his amici argue that the First Amendment prevents the forced administration of antipsychotic drugs because it alters the person's consciousness, and ability to think and communicate, from his pre-medicated psychotic state. Pet. Br. 24-25, 28-30; Rutherford Inst. Am. Br. 7-9; ACLU Am. Br. 6-9; CCLE Am. Br. 3-23; *United States* v. *Brandon*, 158 F.3d 947, 953 (6th Cir. 1998); *Bee* v. *Greaves*, 744 F.2d 1387, 1393-1394 (10th Cir. 1984), cert. denied, 469 U.S. 1214 (1985). The substantive due process inquiry already protects those interests, however, because they are part of the individual's liberty interest in refusing antipsychotic medication whose purpose "is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her *cognitive processes*." *Harper*, 494 U.S. at 229 (emphases added); see also American Psychological Ass'n Am. Br. 9. Because the First Amendment and due process interests are "in large part co-extensive," an order of involuntary medication that complies with substantive due process standards set forth above does not violate the individual's First Amendment rights. *Gomes*, 289 F.3d at 84.

In any event, even if an individual has a residual First Amendment interest that is distinct from his liberty interest, an order of involuntary medication is not a content-based regulation that would require strict scrutiny. See *Simon & Schuster, Inc.* v. *Members of the N.Y State Crime Victims Bd.*, 502 U.S. 105, 118 (1991). The purpose of an order of involuntary medication is to restore a defendant's competence to stand trial; such an order does not "proscrib[e] speech or even expressive conduct because of disapproval of the ideas expressed." *R.A.V.* v. *City of St. Paul*, 505 U.S. 377, 382 (1992) (citations omitted). Indeed, antipsychotic medications, "when properly used to treat the severely mentally ill, positively *promote* First Amendment interests by enhancing abilities to concentrate, read, learn, and communicate." American Psychiatric Ass'n Am. Br. 26; see also pp. 30-31, *supra*. Because an order of involuntary medication is, at most, a content-neutral regulation, it requires a level of intermediate scrutiny. *Ward* v. *Rock Against Racism*, 491 U.S. 781, 799 (1989) (restriction must "promote[] a substantial government interest that would be achieved less effectively absent the regulation") (quoting *United States* v. *Albertini*, 472 U.S. 675, 689 (1985)); accord *United States* v. *O'Brien*, 391 U.S. 367, 377 (1968). Substantive due process requires that the involuntary administra-

[10] There is no basis for petitioner's suggestion (Br. 49 n.10) that physicians employed by the Bureau of Prisons are unable to make independent medical judgments. In its treatment of mentally ill pre-trial detainees, the Bureau of Prisons serves the role of a "benign custodian of one legally committed to it for care and medical treatment." *United States* v. *Charters*, 863 F.2d 302, 312 (4th Cir. 1988) (en banc), cert. denied, 494 U.S. 1016 (1990); cf. *BOP Health Services Manual* Ch. IX, at 4 (in advising courts under 18 U.S.C. 4241(d), "[a]t all times, evaluators should take the position of working for the court, not for the Assistant United States Attorney or the defense attorney").

tion of antipsychotic medication be medically appropriate and that the medication, and not a reasonable less intrusive alternative, is substantially likely to restore competency. That heightened level of scrutiny is consistent with the First Amendment. *Gomes*, 289 F.3d at 84-85.

III. THE INVOLUNTARY ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION IS CONSISTENT WITH A DEFENDANT'S FIFTH AND SIXTH AMENDMENT RIGHTS TO A FAIR TRIAL

A. Medication Is Not Likely To Prejudice Fair Trial Rights

1. In *Riggins*, this Court found that the involuntary administration of an older generation drug, Mellaril, in a dose "within the toxic range" could have violated the defendant's trial rights because the possible side effects of confusion or drowsiness could have affected, "not just [the defendant's] outward appearance, but also the content of his testimony on direct or cross examination, his ability to follow the proceedings, or the substance of his communication with counsel." 504 U.S. at 137; see also *id.* at 142-145 (Kennedy, J., concurring). Thus, in addition to the substantive due process standards set forth above, a court may not order involuntary medication with antipsychotic drugs if the medication is likely to impair the defendant's ability to receive a fair trial.

Where the court has determined that medication is consistent with substantive due process, a court ordinarily will conclude that medication is not likely to prejudice the defendant's fair trial rights. As discussed above, pp. 31-35, due process requires the court to consider the risk of side effects on the defendant in determining whether the medication is medically appropriate. Due process also requires that the medication must be substantially likely to render the defendant able to understand the nature and consequences of the proceedings and assist in his defense. Indeed, the purpose of administering antipsychotic medication is to allow the defendant to think and communicate rationally so he can fairly participate in the legal proceedings and assist his counsel. Those benefits "presumably will also translate into an improved capacity to communicate from the witness stand." *Weston*, 255 F.3d at 884; cf. *Riggins*, 504 U.S. at 136 (noting absence of a finding that the medication was administered to ensure that the defendant was competent to stand trial).

2. There also is good reason to conclude that defendants who are competent by virtue of antipsychotic medication are likely to receive a fair trial. "The great majority of trial-incompetent defendants are restored to trial-competency through the *voluntary* use of these same medications." B. Ladds et al., *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial*, 38 J. Forensic Sci. 1442, 1453 (1993) (*The Disposition of Criminal Charges After Involuntary Medication*) (emphasis added). Similarly, as observed above (at 27), 226 out of the 285 defendants adjudicated to be incompetent under Section 4241(d) (*i.e.*, approximately 80%) within a recent twelve-month period voluntarily accepted treatment.

Although the Bureau does not track the disposition of charges once a defendant is restored to competency, the study by Ladds et al., which examined the disposition of charges of 43 involuntarily medicated defendants, found "no evidence * * * that forced medication per se during a pretrial hospitalization worsens the outcome of pending criminal charges." *The Disposition of Criminal Charges After Involuntary Medication* 1457. Specifically, the study reported that most defendants entered into pleas that resulted in "markedly reduced" charges; that "[s]everal individuals gained freedom from confinement immediately"; and that

medication did not preclude "the successful assertion of an insanity plea." *Id.* at 1452, 1453, 1454.

B. Post-Medication Procedures Ensure That Medication Does Not Unduly Prejudice Fair Trial Rights

1. Where there is no sound reason to conclude, pre-medication, that antipsychotic drugs will impair a particular defendant's fair trial rights, the question whether a drug's side effects, if any, will impair those rights is premature until the drugs are administered. For that reason, the question whether the medication will adversely affect the defendant's fair trial rights "is best determined when the actual effects of the medication are known, that is, after he is medicated." *Weston*, 255 F.3d at 886 n.8; accord *Gomes*, 289 F.3d at 84 ("whatever the risk of side effects may be, we believe that they are best dealt with in the context of the individual case [post-medication] rather than by blanket judicial pronouncements"); J.A. 376 ("[W]e believe that the effects of the medication on [petitioner's] competency and demeanor may properly be considered once the medication is administered.").

The concern expressed in Justice Kennedy's concurrence in *Riggins*, 504 U.S. at 142-145, that side effects will undermine a defendant's right to a fair trial relied, to a large extent, on the side effects of the older generation of drugs. The newer generation of antipsychotic drugs has generally less significant side effects. *Weston*, 255 F.3d at 886 n.7. Indeed, the class of atypical drugs is defined by the drugs' ability to treat psychoses while producing minimal extra-pyramidal side effects. H. Meltzer & S. McGurk, *The Effects of Clozapine, Risperidone, and Olanzapine on Cognitive Function in Schizophrenia* 25(2) Schizophrenia Bull. 233, 235 (1999) ("Atypical antipsychotics are operationally defined as drugs that produce minimal extra pyramidal symptoms (EPS) at doses that produce effective antipsychotic action.").

In addition, some of the concerns, such as that a sedation effect will hinder a defendant's ability to follow the proceedings and assist counsel, directly bear on the issue of competence itself. A defendant who is too drowsy to understand the proceedings or assist counsel will not be found competent to stand trial. A further concern is that medication may be prescribed "for the very purpose of imposing constraints on the defendant's own will." 504 U.S. at 145 (Kennedy, J., concurring). That purpose, however, would not be a legitimate basis for medication designed to restore competence. The goal of restoring competence is to enable the defendant rationally to exercise his will. The medication is vital to attainment of that goal.

If a defendant does suffer any post-treatment side effects that threaten his rights to a fair trial, the ability of "treating physicians and the district court to respond to them substantially reduces the risk they pose to trial fairness." *Weston*, 255 F.3d at 885; accord *Gomes*, 289 F.3d at 84. Side effects can be monitored and controlled by the treating psychiatrist through reducing the dosage, adding a counteracting medication, or choosing a different medication. For example, adverse effects on the defendant's appearance and demeanor can be treated by adjusting the dosage of the medication, administering one of the anti-parkinsonism medications, or changing to one of the atypical medications. American Psychiatric Ass'n, *Practice Guidelines for the Treatment of Psychiatric Disorders* 321 (2000); accord 2 *Kaplan & Sadock* 2265-2266. Moreover, the district court may give appropriate instructions to the jury, such as informing the jury that the defendant is being administered medication, and allowing experts to testify about any effect of the medication. *Weston*, 255 F.3d at 886. The trial day can be shortened if necessary to avoid undue fatigue. Those post-medication procedures are constitutionally sufficient to

protect a defendant's Fifth and Sixth Amendment rights to a fair trial.

2. Petitioner argues (Br. 44) that no post-medication review can ameliorate the fact that medication that *is* effective in restoring competency will deprive a defendant "of the best evidence of his mental state at the time of the alleged crime—his own demeanor in an unmedicated state." That argument apparently posits a trial of an unmedicated psychotic defendant who could testify in a delusional or hallucinogenic state of mind. It is far from clear, however, that such a trial is possible. This Court has never held that a defendant can waive his right to be competent to stand trial, even were the defendant medicated to the point of being made competent to make such a waiver. Cf. *Riggins*, 504 U.S. at 136 ("The question whether a competent criminal defendant may refuse antipsychotic medication if cessation of medication would render him incompetent at trial is not before us."). And, while it is theoretically possible that a defendant at some indeterminate time in the future could become competent and yet remain mentally impaired to a degree sufficient to influence the jury, for seriously ill individuals, that possibility seems highly remote without antipsychotic medication. A constitutional right to refuse competency-restoring medication in order to preserve a hypothetical right to be tried in a mentally-impaired condition thus largely seems to contemplate a trial that will never occur.

Apart from the lack of practicability of the asserted right, "a defendant does not have an absolute right to replicate on the witness stand his mental state at the time of the crime." *Weston*, 255 F.3d at 884. As the D.C. Circuit has explained:

> A defendant asserting a heat-of-passion defense to a charge of first degree murder does not have the right to whip up a frenzy in court to show his capacity for rage, nor does a defendant claiming intoxication have the right to testify under the influence. There is little meaningful distinction between these cases and medication-induced competence to stand trial.

Ibid. Indeed, the American Psychiatric Association advises (Am. Br. 29) that "[a]n individual's psychotic state may not be evident in his or her appearance or demeanor" and that, even were the defendant to remain unmedicated at trial, the passage of time and his surroundings and circumstances at trial may alter his demeanor "from what it was at the time of the charged offense." There is, in addition, no necessary correlation between a defendant's present mental condition and whether his condition at the time of the alleged criminal act met the jurisdiction's legal definition of insanity (or other legal defenses). And there are ample other ways for a defendant to prove his impaired mental state at the time of the offense—through the testimony of examining physicians and other witnesses, taped interviews, psychiatric reports, and instructions to the jury about the effects of medication. Finally, the defendant himself can testify to his previous hallucinations or delusions. *Weston*, 255 F.3d at 884-885.

IV. THE ORDER FOR INVOLUNTARY ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION IN THIS CASE IS PROPER

The court of appeals held that the government had proved the effectiveness of medication to restore petitioner's competency, the medical appropriateness of antipsychotic drugs, and the lack of reasonable alternatives "by clear and convincing evidence." J.A. 375.[11] The court of appeals also found

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[11] The importance and nature of the interests at stake here are comparable to the interests bearing on the decision to civilly commit an individual, *Addington* v. *Texas*, 441 U.S. at 427, in which the Court adopted the clear and convincing standard of proof. See also, *e.g.*, *Santosky* v. *Kramer*, 455 U.S. 745, 756-757 (1982) (termination of parental rights); *Woodby* v.

that there was evidence that petitioner's fair trial rights could be safeguarded if he was restored to competence by medication. J.A. 375-376. Those determinations are correct.

A. Antipsychotic Medication Is Substantially Likely And Necessary To Restore Petitioner's Competence

1. The record in this case establishes that antipsychotic medication is substantially likely to render petitioner competent to stand trial. Dr. DeMier testified to his belief that petitioner could "be restored to competency, as a result of treatment with anti-psychotic medications." J.A. 176. He testified that he had been involved in the treatment of two patients with delusional disorder who had been administered antipsychotic medication and that one patient had regained competency and the other had shown significant improvement. J.A. 174-176, 184-185.

Dr. Wolfson testified that he had treated between 1000 and 2000 patients with antipsychotic medication and that most of them had positive results. J.A. 233. He stated that he had successfully used antipsychotic medication four out of five times to restore the competency of patients with delusional disorder. J.A. 240-241, 261-263. Dr. Wolfson noted that the conventional wisdom was that patients with delusional disorder respond less well to antipsychotic medication than patients with other psychoses, but he doubted that conclusion based on his own experience. J.A. 243-244, 277. He observed that favorable results documented in a small series of case reports in the medical literature mirrored his experience. J.A. 243-244. Dr. Wolfson opined that, based on his experience, antipsychotic medication stood "a good chance" of restoring petitioner's competency. J.A. 242.

The American Psychological Association states (Am. Br. 17) that "there is no consensus among researchers that

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INS, 385 U.S. 276, 285-286 (1966) (deportation). That standard is therefore the appropriate one in this setting.

delusional disorder, persecutory type will respond favorably to antipsychotic drugs." The American Psychiatric Association, however, has concluded (Am. Br. 19-20) that "the evidence respecting treatment of delusional disorder," while "less definitive than for schizophrenia and other more common psychotic illnesses," "supports the findings about medication here–its medical appropriateness, the prospects for restoring competence, and the lack of realistic alternatives." See A. Munro, *Delusional Disorder, Paranoia and Related Illnesses* 6 (Cambridge Univ. Press 1999) ("Many anecdotal treatment results, and a small number of double-blind drug trials, appear to show a *consensus* that delusional disorder, despite its traditional resistance to treatment, can now be regarded as an eminently treatable illness.") (emphasis added); see also 1 *Kaplan & Sadock* 1263 (review of delusional disorder case studies in literature "indicated that 80.8 percent of cases either recovered fully or partially" as a result of antipsychotic medication).

In any event, there is no sound basis for imposing a constitutional requirement that courts in every case review the medical literature to determine whether a medical "consensus" has been achieved with respect to a particular course of treatment. In analogous contexts, this Court has not required such a showing but rather has required that the physician exercise her "professional judgment" in treating an involuntarily confined patient. *Youngberg*, 457 U.S. at 322; *Harper*, 494 U.S. at 230, 233; cf. *Daubert*, 509 U.S. at 594 ("general acceptance" is not a necessary precondition for admissibility of expert testimony under Federal Rules of Evidence).

2. The record equally establishes that there is no less intrusive means of treating petitioner's psychosis to render him competent to stand trial. Dr. DeMier testified at the evidentiary hearing that "anti-psychotic medication [was] clearly indicated, as it [was] the only treatment that we

could reasonably expect to improve [petitioner's] condition." J.A. 176. He believed that there was no "other effective method of treating [petitioner's] symptoms at this time," J.A. 177, and that antipsychotic medication was "the only effective means to improve his mental state." J.A. 184. Dr. Wolfson testified that antipsychotic medication was necessary to alleviate petitioner's symptoms before he could be treated with other non-drug therapies. J.A. 232-233, 262-264.

Neither petitioner nor the amici make any claim in this Court that there is a less intrusive means of restoring his competence to stand trial. American Psychological Ass'n Am. Br. 13-14 & n.11 ("For individuals with some diagnoses, however,—including delusional disorder—particular features of the disorder may present considerable obstacles to the effectiveness of non-drug therapy."); accord American Psychiatric Ass'n Am. Br. 20-21. Similarly, petitioner's expert, Dr. Cloninger "was not able to recommend a less intrusive alternative to restore [petitioner] to competency." J.A. 372.

B. Antipsychotic Medication Is Medically Appropriate

The record in this case also establishes that the likelihood and gravity of side effects of the antipsychotic medication do not outweigh the medical benefits to petitioner. Dr. DeMier acknowledged that there were "potentially significant side effects" from the medication, J.A. 185-187, but he believed that the medication provided "potentially, very significant recovery from symptoms." J.A. 185. Dr. Wolfson also acknowledged that antipsychotic medication had the potential to cause "unpleasant" side effects, such as dystonic reaction and sedation, J.A. 233-234, 240, but he believed that those side effects could be mitigated by other medicines or treatments. J.A. 234-235. As the court of appeals concluded, "the government proved that the side-effects produced by the

medication could be minimized through careful treatment and changing medications and dosages." J.A. 374.

Dr. DeMier also testified that the delay in treatment could adversely affect petitioner both by lengthening the amount of time it would take for the treatment to work and by diminishing the optimal response to the treatment. J.A. 165, 216. He stated that petitioner's condition had deteriorated since June 1999 and would continue to deteriorate if he were not treated with antipsychotic medication. J.A. 165-167, 172. Dr. Wolfson likewise anticipated that petitioner's condition would continue to deteriorate absent antipsychotic medication. J.A. 228.

Petitioner argues (Br. 18, 31, 33, 49) that the courts below could not determine whether antipsychotic medication was medically appropriate or effective in restoring competency, since Dr. Wolfson testified at the hearing that he did not want to commit himself to a particular drug because he wanted to give petitioner some control over his course of treatment. J.A. 238-239. Dr. Wolfson did recommend, however, that the atypical drugs quetiapine (Seroquel), olanzapine (Zyprexa), and ziprasadone (Geodon) "are the ones that make the most sense" and are the "most likely to have a benign side effect * * * profile." J.A. 238, 239. The court of appeals thus properly rejected petitioner's contention that "he was not given the opportunity to make specific objections to specific drugs." J.A. 374.

Dr. Wolfson's approach was medically proper, since the decision as to a particular medication and its precise dose must be determined according to what is appropriate at the time the medication is administered, given the patient's condition, and state of medical knowledge. There also is no point to seeking a judicial order authorizing only one form of a drug, for instance, an injectable conventional drug, if the patient, upon being advised of an involuntary medication order, decides to take one of the newer atypical drugs avail-

able only in a pill. Similarly, dosages may need adjustment and further medication may need to be prescribed in response to any side effects. Finally, the patient himself may wish to play some role after being advised of the risk of side effects. J.A. 297 (testimony of Dr. Wolfson) ("I see no benefit to saying, 'I will pick this drug now,' dogmatically, if it turns out that [petitioner] prefers Quetiapine to Olazapine, then there [is] no reason why he shouldn't have some input."). Any requirement of prior judicial approval for those subsidiary medical decisions could seriously interfere with the best medical interests of the patient and likewise could disrupt the government's attempt to render the defendant competent to stand trial.[12]

C. The Courts Below Appropriately Considered The Effects Of Antipsychotic Medication On Petitioner's Fair Trial Rights

The courts below found the evidence sufficient to indicate that petitioner "would be able to participate meaningfully in his trial while he is under the influence of the medication." J.A. 376. Petitioner errs in presuming (Br. 45) that the involuntary administration of antipsychotic medication is impermissible because it would impair his trials rights in being able "to pay attention to witnesses, attorneys, or anyone else in the courtroom, to listen and respond to questions, and to offer comments about the proceedings." In those situations, no trial would proceed because petitioner

[12] The government's ability to retain custody over a person to render him competent is not uncabined. Section 4241 allows the Attorney General to retain custody of a defendant for treatment only for a "reasonable period of time" during which there is "substantial probability" the person "will attain the capacity to permit the trial to proceed." 18 U.S.C. 4241(d)(2)(A). Although petitioner objects (Br. 21, 23, 36 n.5, 40) to the length of his confinement under Section 4241(d)(2)(A) during which he has not received treatment, petitioner has resisted all attempts to restore his competency through medication, and petitioner does not contend that there are alternative effective forms of treatment.

would not be competent to stand trial. As the district court explained, "[a] showing that he is unable to assist properly in his defense would result in a continued finding that defendant is not * * * competent to stand trial." J.A. 351.

Petitioner also argues that antipsychotic medication could render his appearance "drugged and listless" (Br. 44), "nervous and anxious or rigid and remorseless" (Br. 45), or "stiff[]" (Br. 46). As the magistrate judge explained, however, "Dr. Wolfson intends to use atypical anti-psychotic drugs with a low side effect profile when medicating [petitioner.] Dr. Wolfson also intends to avoid sedating [petitioner], because his purpose is to allow him to participate meaningfully in his trial." J.A. 334-335; see also J.A. 234 ("Obviously, our goal is to get patients back so they can defend their cases, and having them sleeping in the courtroom is not the desirable goal, so I tend to choose medications that do that less.").

Furthermore, the district court can examine all of petitioner's fair trial claims after petitioner is treated. Until that time, petitioner's hypotheses about the effects from medication on his demeanor and cognitive abilities are premature. Indeed, the district court in this case "noted its willingness to re-examine [petitioner's] Sixth Amendment claim after the medication regimen has begun." J.A. 376; see also J.A. 352 ("In its capacity as the trial court in this case, the Court here states that if medication is administered and the defense presents argument and evidence concerning its adverse effect on [petitioner] to defend himself, the Court will give the issue careful consideration."). In short, "[t]he evidence offered, that the drugs should not interfere with [petitioner's] right to a fair trial, as well as post-medication procedures that ensure he will not be tried unfairly, are sufficient to protect" petitioner's right to a fair trial. J.A. 376.

Petitioner's intent to present a diminished capacity defense (Br. 13-14, 43-44) also does not justify the conclusion

that he cannot be involuntarily medicated in order to restore his competency. Petitioner does not argue that he can constitutionally be tried in his unmedicated delusional state, see p. 42, *supra*, and on this record, medication is the *sole* means reasonably likely to render petitioner able to stand trial on the fraud (and attempted murder charges) in the foreseeable future. Petitioner also does not dispute that there is other extensive evidence of his history of mental illness, and there is no basis for presuming at this time that the medication will prejudice petitioner in testifying about his prior delusional beliefs. In those circumstances, petitioner has no constitutional right to refuse the administration of medically appropriate antipsychotic medication necessary to obtain an adjudication of the pending charges.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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APPENDIX

1. The First Amendment to the United States Constitution provides in relevant part:

> Congress shall make no law * * * abridging the freedom of speech.

2. The Fifth Amendment to the United States Constitution provides in relevant part:

> No person shall * * * be deprived of life, liberty, or property, without due process of law.

3. The Sixth Amendment to the United States Constitution provides in relevant part:

> In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury * * *, and to have the Assistance of Counsel for his defence.

4. Section 4241, of Title 18, U.S.C. provides:

§ 4241. Determination of mental competency to stand trial

(a) MOTION TO DETERMINE COMPETENCY OF DEFENDANT.—At any time after the commencement of a prosecution for an offense and prior to the sentencing of the defendant, the defendant or the attorney for the Government may file a motion for a hearing to determine the mental competency of the defendant. The court shall grant the motion, or shall order such a hearing on its own motion, if there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense.

(b) PSYCHIATRIC OR PSYCHOLOGICAL EXAMINATION AND REPORT.—Prior to the date of the hearing, the court may order that a psychiatric or psychological examination of the defendant be conducted, and that a psychiatric or psychological report be filed with the court, pursuant to the provisions of section 4247 (b) and (c).

(c) HEARING.—The hearing shall be conducted pursuant to the provisions of section 4247(d).

(d) DETERMINATION AND DISPOSITION.—If, after the hearing, the court finds by a preponderance of the evidence that the defendant is presently suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense, the court shall commit the defendant to the custody of the Attorney General. The Attorney General shall hospitalize the defendant for treatment in a suitable facility—

(1) for such a reasonable period of time, not to exceed four months, as is necessary to determine whether there is a substantial probability that in the foreseeable future he will attain the capacity to permit the trial to proceed; and

(2) for an additional reasonable period of time until—

(A) his mental condition is so improved that trial may proceed, if the court finds that there is a substantial probability that within such additional period of time he will attain the capacity to permit the trial to proceed; or

(B) the pending charges against him are disposed of according to law;

whichever is earlier.

If, at the end of the time period specified, it is determined that the defendant's mental condition has not so improved as to permit the trial to proceed, the defendant is subject to the provisions of section 4246.

(e) DISCHARGE.—When the director of the facility in which a defendant is hospitalized pursuant to subsection (d) determines that the defendant has recovered to such an extent that he is able to understand the nature and consequences of the proceedings against him and to assist properly in his defense, he shall promptly file a certificate to that effect with the clerk of the court that ordered the commitment. The clerk shall send a copy of the certificate to the defendant's counsel and to the attorney for the Government. The court shall hold a hearing, conducted pursuant to the provisions of section 4247(d), to determine the competency of the defendant. If, after the hearing, the court finds by a preponderance of the evidence that the defendant has recovered to such an extent that he is able to understand the nature and consequences of the proceedings against him and to assist properly in his defense, the court shall order his immediate discharge from the facility in which he is hospitalized and shall set the date for trial. Upon discharge, the defendant is subject to the provisions of chapter 207.

(f) ADMISSIBILITY OF FINDING OF COMPETENCY.—A finding by the court that the defendant is mentally competent to stand trial shall not prejudice the defendant in raising the issue of his insanity as a defense to the offense charged, and shall not be admissible as evidence in a trial for the offense charged.

5. Section 4246 of Title 18, U.S.C., provides:

§ 4246. Hospitalization of a person due for release but suffering from mental disease or defect

(a) INSTITUTION OF PROCEEDING.—If the director of a facility in which a person is hospitalized certifies that a person in the custody of the Bureau of Prisons whose sentence is about to expire, or who has been committed to the custody of the Attorney General pursuant to section 4241(d), or against whom all criminal charges have been dismissed solely for reasons related to the mental condition of the person, is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another, and that suitable arrangements for State custody and care of the person are not available, he shall transmit the certificate to the clerk of the court for the district in which the person is confined. The clerk shall send a copy of the certificate to the person, and to the attorney for the Government, and, if the person was committed pursuant to section 4241(d), to the clerk of the court that ordered the commitment. The court shall order a hearing to determine whether the person is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another. A certificate filed under this subsection shall stay the release of the person pending completion of procedures contained in this section.

(b) PSYCHIATRIC OR PSYCHOLOGICAL EXAMINATION AND REPORT.—Prior to the date of the hearing, the court may order that a psychiatric or psychological examination of the defendant be conducted, and that a psychiatric or psychological report be filed with the court, pursuant to the provisions of section 4247(b) and (c).

(c) HEARING.—The hearing shall be conducted pursuant to the provisions of section 4247(d).

(d) DETERMINATION AND DISPOSITION.—If, after the hearing, the court finds by clear and convincing evidence that the person is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another, the court shall commit the person to the custody of the Attorney General. The Attorney General shall release the person to the appropriate official of the State in which the person is domiciled or was tried if such State will assume responsibility for his custody, care, and treatment. The Attorney General shall make all reasonable efforts to cause such a State to assume such responsibility. If, notwithstanding such efforts, neither such State will assume such responsibility, the Attorney General shall hospitalize the person for treatment in a suitable facility, until—

(1) such a State will assume such responsibility; or

(2) the person's mental condition is such that his release, or his conditional release under a prescribed regimen of medical, psychiatric, or psychological care or treatment would not create a substantial risk of bodily injury to another person or serious damage to property of another;

whichever is earlier. The Attorney General shall continue periodically to exert all reasonable efforts to cause such a State to assume such responsibility for the person's custody, care, and treatment.

(e) DISCHARGE.—When the director of the facility in which a person is hospitalized pursuant to subsection (d) determines that the person has recovered from his mental disease or defect to such an extent that his release would no

longer create a substantial risk of bodily injury to another person or serious damage to property of another, he shall promptly file a certificate to that effect with the clerk of the court that ordered the commitment. The clerk shall send a copy of the certificate to the person's counsel and to the attorney for the Government. The court shall order the discharge of the person or, on the motion of the attorney for the Government or on its own motion, shall hold a hearing, conducted pursuant to the provisions of section 4247(d), to determine whether he should be released. If, after the hearing, the court finds by a preponderance of the evidence that the person has recovered from his mental disease or defect to such an extent that–

(1) his release would no longer create a substantial risk of bodily injury to another person or serious damage to property of another, the court shall order that he be immediately discharged; or

(2) his conditional release under a prescribed regimen of medical, psychiatric, or psychological care or treatment would no longer create a substantial risk of bodily injury to another person or serious damage to property of another, the court shall—

(A) order that he be conditionally discharged under a prescribed regimen of medical, psychiatric, or psychological care or treatment that has been prepared for him, that has been certified to the court as appropriate by the director of the facility in which he is committed, and that has been found by the court to be appropriate; and

(B) order, as an explicit condition of release, that he comply with the prescribed regimen of medical, psychiatric, or psychological care or treatment.

The court at any time may, after a hearing employing the same criteria, modify or eliminate the regimen of medical, psychiatric, or psychological care or treatment.

(f) REVOCATION OF CONDITIONAL DISCHARGE.—The director of a medical facility responsible for administering a regimen imposed on a person conditionally discharged under subsection (e) shall notify the Attorney General and the court having jurisdiction over the person of any failure of the person to comply with the regimen. Upon such notice, or upon other probable cause to believe that the person has failed to comply with the prescribed regimen of medical, psychiatric, or psychological care or treatment, the person may be arrested, and, upon arrest, shall be taken without unnecessary delay before the court having jurisdiction over him. The court shall, after a hearing, determine whether the person should be remanded to a suitable facility on the ground that, in light of his failure to comply with the prescribed regimen of medical, psychiatric, or psychological care or treatment, his continued release would create a substantial risk of bodily injury to another person or serious damage to property of another.

(g) RELEASE TO STATE OF CERTAIN OTHER PERSONS.—If the director of a facility in which a person is hospitalized pursuant to this chapter certifies to the Attorney General that a person, against whom all charges have been dismissed for reasons not related to the mental condition of the person, is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another, the Attorney General shall release the person to the appropriate official of the State in which the person is domiciled or was tried for the purpose of institution of State proceedings for civil commitment. If neither such State will assume such responsibil-

ity, the Attorney General shall release the person upon receipt of notice from the State that it will not assume such responsibility, but not later than ten days after certification by the director of the facility.

(h) DEFINITION.—As used in this chapter the term "State" includes the District of Columbia.

6. Section 4247 of Title 18, U.S.C., provides:

§ 4247. General provisions for chapter

(a) DEFINITIONS.—As used in this chapter—

(1) "rehabilitation program" includes—

(A) basic educational training that will assist the individual in understanding the society to which he will return and that will assist him in understanding the magnitude of his offense and its impact on society;

(B) vocational training that will assist the individual in contributing to, and in participating in, the society to which he will return;

(C) drug, alcohol, and other treatment programs that will assist the individual in overcoming his psychological or physical dependence; and

(D) organized physical sports and recreation programs;

(2) "suitable facility" means a facility that is suitable to provide care or treatment given the nature of the offense and the characteristics of the defendant; and

(3) "State" includes the District of Columbia.

(b) PSYCHIATRIC OR PSYCHOLOGICAL EXAMINATION.—A psychiatric or psychological examination ordered pursuant to this chapter shall be conducted by a

licensed or certified psychiatrist or psychologist, or, if the court finds it appropriate, by more than one such examiner. Each examiner shall be designated by the court, except that if the examination is ordered under section 4245 or 4246, upon the request of the defendant an additional examiner may be selected by the defendant. For the purposes of an examination pursuant to an order under section 4241, 4244, or 4245, the court may commit the person to be examined for a reasonable period, but not to exceed thirty days, and under section 4242, 4243, or 4246, for a reasonable period, but not to exceed forty-five days, to the custody of the Attorney General for placement in a suitable facility. Unless impracticable, the psychiatric or psychological examination shall be conducted in the suitable facility closest to the court. The director of the facility may apply for a reasonable extension, but not to exceed fifteen days under section 4241, 4244, or 4245, and not to exceed thirty days under section 4242, 4243, or 4246, upon a showing of good cause that the additional time is necessary to observe and evaluate the defendant.

(c) PSYCHIATRIC OR PSYCHOLOGICAL REPORTS.—A psychiatric or psychological report ordered pursuant to this chapter shall be prepared by the examiner designated to conduct the psychiatric or psychological examination, shall be filed with the court with copies provided to the counsel for the person examined and to the attorney for the Government, and shall include—

(1) the person's history and present symptoms;

(2) a description of the psychiatric, psychological, and medical tests that were employed and their results;

(3) the examiner's findings; and

(4) the examiner's opinions as to diagnosis, prognosis, and—

(A) if the examination is ordered under section 4241, whether the person is suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense;

(B) if the examination is ordered under section 4242, whether the person was insane at the time of the offense charged;

(C) if the examination is ordered under section 4243 or 4246, whether the person is suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another;

(D) if the examination is ordered under section 4244 or 4245, whether the person is suffering from a mental disease or defect as a result of which he is in need of custody for care or treatment in a suitable facility; or

(E) if the examination is ordered as a part of a presentence investigation, any recommendation the examiner may have as to how the mental condition of the defendant should affect the sentence.

(d) HEARING.—At a hearing ordered pursuant to this chapter the person whose mental condition is the subject of the hearing shall be represented by counsel and, if he is financially unable to obtain adequate representation, counsel shall be appointed for him pursuant to section 3006A. The person shall be afforded an opportunity to testify, to present evidence, to subpoena witnesses on his behalf, and to confront and cross-examine witnesses who appear at the hearing.

(e) PERIODIC REPORT AND INFORMATION REQUIREMENTS. —(1) The director of the facility in which a person is hospitalized pursuant to—

(A) section 4241 shall prepare semiannual reports; or

(B) section 4243, 4244, 4245, or 4246 shall prepare annual reports concerning the mental condition of the person and containing recommendations concerning the need for his continued hospitalization. The reports shall be submitted to the court that ordered the person's commitment to the facility and copies of the reports shall be submitted to such other persons as the court may direct. A copy of each such report concerning a person hospitalized after the beginning of a prosecution of that person for violation of section 871, 879, or 1751 of this title shall be submitted to the Director of the United States Secret Service. Except with the prior approval of the court, the Secret Service shall not use or disclose the information in these copies for any purpose other than carrying out protective duties under section 3056(a) of this title.

(2) The director of the facility in which a person is hospitalized pursuant to section 4241, 4243, 4244, 4245, or 4246 shall inform such person of any rehabilitation programs that are available for persons hospitalized in that facility.

(f) VIDEOTAPE RECORD.—Upon written request of defense counsel, the court may order a videotape record made of the defendant's testimony or interview upon which the periodic report is based pursuant to subsection (e). Such videotape record shall be submitted to the court along with the periodic report.

(g) HABEAS CORPUS UNIMPAIRED.—Nothing contained in section 4243 or 4246 precludes a person who is committed under either of such sections from establishing by writ of habeas corpus the illegality of his detention.

(h) DISCHARGE.—Regardless of whether the director of the facility in which a person is hospitalized has filed a certificate pursuant to the provisions of subsection (e) of section 4241, 4244, 4245, or 4246, or subsection (f) of section 4243, counsel for the person or his legal guardian may, at any time during such person's hospitalization, file with the court that ordered the commitment a motion for a hearing to determine whether the person should be discharged from such facility, but no such motion may be filed within one hundred and eighty days of a court determination that the person should continue to be hospitalized. A copy of the motion shall be sent to the director of the facility in which the person is hospitalized and to the attorney for the Government.

(i) AUTHORITY AND RESPONSIBILITY OF THE ATTORNEY GENERAL.—The Attorney General–

(A) may contract with a State, a political subdivision, a locality, or a private agency for the confinement, hospitalization, care, or treatment of, or the provision of services to, a person committed to his custody pursuant to this chapter;

(B) may apply for the civil commitment, pursuant to State law, of a person committed to his custody pursuant to section 4243 or 4246;

(C) shall, before placing a person in a facility pursuant to the provisions of section 4241, 4243, 4244, 4245, or 4246, consider the suitability of the facility's rehabilitation programs in meeting the needs of the person; and

(D) shall consult with the Secretary of the Department of Health and Human Services in the general implementation of the provisions of this chapter and in the establishment of standards for facilities used in the implementation of this chapter.

(j) Sections 4241, 4242, 4243, and 4244 do not apply to a prosecution under an Act of Congress applicable exclusively to the District of Columbia or the Uniform Code of Military Justice.

7. Section 549.43 of Title 28 of the C.F.R. provides:

§ 549.43 Involuntary psychiatric treatment and medication.

Title 18 U.S.C. 4241-4247 and federal court decisions require that certain procedures be followed prior to the involuntary administration of psychiatric treatment and medication to persons in the custody of the Attorney General. Court commitment for hospitalization provides the judicial due process hearing, and no further judicial authorization is needed for the admission decision. However, in order to administer treatment or psychotropic medication on an involuntary basis, further administrative due process procedures, as specified in this section, must be provided to the inmate. Except as provided for in paragraph (b) of this section, the procedures outlined herein must be followed after a person is committed for hospitalization and prior to administering involuntary treatment, including medication.

(a) *Procedures:* When an inmate will not or cannot provide voluntary written informed consent for psychotropic medication, the inmate will be scheduled for an administrative hearing. Absent an emergency situation, the inmate will not be medicated prior to the hearing. In regard to the hearing, the inmate will be given the following procedural safeguards:

(1) Staff shall provide 24-hour advance written notice of the date, time, place, and purpose of the hearing, including the reasons for the medication proposal.

(2) Staff shall inform the inmate of the right to appear at the hearing, to present evidence, to have a staff representative, to request witnesses, and to request that witnesses be questioned by the staff representative or by the person conducting the hearing. If the inmate does not request a staff representative, or requests a staff representative with insufficient experience or education, the institution mental health division administrator shall appoint a staff representative. Witnesses should be called if they have information relevant to the inmate's mental condition and/or need for medication, and if they are reasonably available. Witnesses who only have repetitive information need not be called.

(3) The hearing is to be conducted by a psychiatrist who is not currently involved in the diagnosis or treatment of the inmate.

(4) The treating/evaluating psychiatrist/clinician must be present at the hearing and must present clinical data and background information relative to the need for medication. Members of the treating/evaluating team may also attend the hearing.

(5) The psychiatrist conducting the hearing shall determine whether treatment or psychotropic medication is necessary in order to attempt to make the inmate competent for trial or is necessary because the inmate is dangerous to self or others, is gravely disabled, or is unable to function in the open population of a mental health referral center or a regular prison. The psychiatrist shall prepare a written report regarding the decision.

(6) The inmate shall be given a copy of the report and shall be advised that he or she may submit an appeal to the institution mental health division administrator

regarding the decision within 24 hours of the decision and that the administrator shall review the decision within 24 hours of the inmate's appeal. The administrator shall ensure that the inmate received all necessary procedural protections and that the justification for involuntary treatment or medication is appropriate. Upon request of the inmate, the staff representative shall assist the inmate in preparing and submitting the appeal.

(7) If the inmate appeals, absent a psychiatric emergency, medication will not be administered before the administrator's decision. The inmate's appeal, which may be handwritten, must be filed within 24 hours of the inmate's receipt of the decision.

(8) A psychiatrist, other than the attending psychiatrist, shall provide follow-up monitoring of the patient's treatment or medication at least once every 30 days after the hearing. The follow-up shall be documented in the medical record.

(b) *Emergencies*: For purpose of this subpart, a psychiatric emergency is defined as one in which a person is suffering from a mental illness which creates an immediate threat of bodily harm to self or others, serious destruction of property, or extreme deterioration of functioning secondary to psychiatric illness. During a psychiatric emergency, psychotropic medication may be administered when the medication constitutes an appropriate treatment for the mental illness and less restrictive alternatives (e.g., seclusion or physical restraint) are not available or indicated, or would not be effective.

(c) *Exceptions*: Title 18 United States Code, sections 4241 through 4247 do not apply to military prisoners, unsentenced Immigration and Naturalization Service (INS)

detainees, unsentenced prisoners in Bureau custody as a result of a court order (e.g. a civil contemnor), state or territorial prisoners, and District of Columbia Code offenders. For those persons not covered by sections 4241-4247, the decision to involuntarily admit the person to the hospital must be made at an administrative hearing meeting the requirements of Vitek v. Jones. The decision to provide involuntary treatment, including medication, shall nonetheless be made at an administrative hearing in compliance with § 549.43.

(8)
Supreme Court, U.S.
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In The

Supreme Court of the United States

CHARLES THOMAS SELL, D.D.S.,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Eighth Circuit

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ARGUMENT

I. DR. SELL'S INTEREST IN AVOIDING FORCED MEDICATION IS FUNDAMENTAL.

Whether articulated as freedom of thought, right to bodily integrity, right to refuse unwanted medical treatment or right to privacy, the right to be free from unwanted physical and mental intrusions has long been recognized as an integral part of an individual's constitutional freedom. In his opening brief Dr. Sell articulates the constitutional and historic bases for recognizing that the right to remain free from forced medication is fundamental.

The government recognizes that, at minimum, the right that Dr. Sell asserts is significant. Indeed, the government does not argue that the right to refuse unwanted medical treatment is not fundamental or try to distinguish the right to refuse unwanted medical treatment from other fundamental rights that this Court has recognized. This Court recently acknowledged that "[t]he right to think is the beginning of freedom." *Ashcroft v. Free Speech Coalition*, 122 S. Ct. 1389, 1403 (2002). Dr. Sell's rights to form thoughts, to speak, and to remain free from unwanted bodily intrusion are fundamental.

A. Dr. Sell Has A Fundamental Fifth Amendment Right In Refusing Forced Medication With Antipsychotic Drugs.

This Court has repeatedly recognized an individual's fundamental right to "bodily integrity" and to make "choices central to personal dignity and autonomy." *See Planned Parenthood v. Casey*, 505 U.S. 833, 851, 857 (1992); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (recognizing right to use contraceptives is fundamental);

Rochin v. California, 342 U.S. 165, 171-74 (1952) (finding government cannot force individual to take an emetic based on suspicion that individual swallowed morphine capsules); *see also Washington v. Harper*, 494 U.S. 210, 241 (1990) (dissent) (three Justices viewed the right to refuse antipsychotics as fundamental). This right has been deemed so important, that the Court has protected the right, even when a state government has asserted as an interest the protection of life. *Planned Parenthood*, 505 U.S. at 857. Making a determination about one's own psychology and about one's own physical integrity are among the most important personal decisions an individual can make. Dr. Sell's interest in making these decisions is even more important when the government's intrusion may cause serious, long-lasting side effects and the medical establishment cannot even agree on the treatment for his psychiatric condition. *See generally* Amicus Briefs of American Psychiatric Association and American Psychological Association (expressing contrary views on treatment of delusional disorder, persecutory type). In light of "our Nation's history, legal traditions, and practices," Dr. Sell has a fundamental Fifth Amendment right in avoiding forced medication with antipsychotic drugs. *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997).

B. Dr. Sell Has A Fundamental First Amendment Interest In Not Having His Speech And Thought Manipulated By The Government.

The involuntary druggir ? of Dr. Sell implicates First Amendment rights separate and distinct from his substantive due process rights. "Where, as here, medication which is potentially mind altering is concerned, the threat to individual rights goes beyond a threat of physical intrusion

and threatens an intrusion into the mind." *United States v. Charters*, 829 F.2d 479, 492 (4th Cir. 1987). The makers of our Constitution recognized the significance of man's "spiritual nature, of his feelings and of his intellect. [They] sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone – the most comprehensive of rights and the right most valued by civilized men." *Stanley v. Georgia*, 394 U.S. 557, 564 (1969) (quoting *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting)). Thus, the protection of an individual's right to believe and think as he or she sees fit has long been viewed as within the protection of the First Amendment by this Court. *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624, 641 (1943); *Wooley v. Maynard*, 430 U.S. 705, 713 (1977); *United States v. Reidel*, 402 U.S. 351, 359 (1971) (Harlan, J., concurring). Here, the government seeks to alter Dr. Sell's mind and the manner in which he forms thought solely for prosecutorial purposes.[1]

The government concedes in its Brief that the First Amendment protects "expressive and freedom-of-thought interests" and that Dr. Sell may have a residual First Amendment interest that is distinct from a liberty interest.

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[1] "Such mind altering medication has the potential to allow the government to alter or control thinking and thereby to destroy the independence of thought and speech so crucial to a free society." *United States v. Charters*, 829 F.2d 479, 492 (4th Cir. 1987) "[T]he power to control men's minds is 'wholly inconsistent' not only with the 'philosophy of the first amendment but with virtually any concept of liberty.'" *Davis v. Hubbard*, 506 F. Supp. 915, 933 (N.D. Ohio 1980) (quoting *Stanley v. Georgia*, 394 U.S. at 565-66).

Government's Brief at 13, 37. The government then argues, however, that forced medication of Dr. Sell is "content-neutral" and, therefore, application of intermediate scrutiny is appropriate. Contrary to the government's assertion, the involuntary drugging sought in this case is not content-neutral. The content of Dr. Sell's thoughts is precisely the reason the government seeks to medicate him. The very purpose of the government's efforts is to change Dr. Sell's thought and speech so that he does not evidence persecutory delusions. *Harper*, 494 U.S. at 229 (recognizing that the purpose of antipsychotic drugs is to alter the chemical balance in the patient's brain).

Dr. Sell believes that the FBI is plotting to discredit and/or kill him. (Record 807, 809; 1999 FPR at 6). He believes the Branch Davidian Compound at Waco, Texas was intentionally burned by government agents. (Record 376-77). He believes that his statements about witnessing these events were forwarded to the FBI and that in an effort to conceal the truth about Waco, the FBI has arranged for criminal charges to be brought against him and might seek to kill him. (Record 377-78). While Dr. Sell's view of the world and political beliefs may seem unusual in these respects, until Dr. Sell is adjudged incompetent to make medical decisions, he must be permitted to think his thoughts, and speak his mind, even if the government does not like what he thinks or says. It is these thoughts the government wishes to suppress and alter, to change the way he thinks, so that he will appear to be competent.

An individual's freedom of thought must not be infringed, even if the individual is regarded as "mentally ill." Many noted world leaders, authors, and artists have suffered from mental illness. Abraham Lincoln suffered from severe and incapacitating depressions that occasionally lead

to thoughts of suicide. *See* National Alliance for the Mentally Ill, http://www.nami.org/helpline/peoplew.htm (identifying famous individuals who suffered from mental illness). Ludwig van Beethoven experienced bipolar disorder. *See id.* Isaac Newton and Ernest Hemingway both suffered from mental illnesses. *See id.* Dr. Sell does not ask that the Court accept his views and thoughts or even that it acknowledge any positive aspects of these thoughts. What should be noted, however, is that society has benefited through diverse thinking.[2]

Even assuming for the sake of argument that the government's efforts were content-neutral, strict scrutiny still must apply. The primary case upon which the government relies, *Ward v. Rock Against Racism*, deals with the government's ability to impose content-neutral time, place, or manner restrictions on speech.[3] 491 U.S. 781, 792 (1989). The forced medication of Dr. Sell with its potentially serious and life-threatening side effects cannot be characterized simply as a time, place, or manner restriction. *See Reno v. ACLU*, 521 U.S. 844, 868 (1997) (recognizing that blanket restrictions on speech cannot be considered as a time, place, or manner regulation). Further, this Court has

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[2] As Emily Dickinson eloquently stated: "Much madness is divinest sense/To a discerning eye; much sense the starkest madness. 'T is the majority/In this, as all, prevails. Assent, and you are sane; Demur, – you're straightway dangerous/And handled with a chain." Emily Dickinson, *The Complete Poems of Emily Dickinson*, Part I: Life (1924).

[3] The remaining cases cited by the government concern restrictions on conduct that incidentally affect speech, and are thus inapposite. Even the government does not suggest that the drugging of Dr. Sell is aimed primarily at his conduct and would only incidentally affect his speech. *United States v. Albertini*, 472 U.S. 675, 689 (1985); *United States v. O'Brien*, 391 U.S. 367, 375 (1968).

recognized on several occasions that government efforts that appear to be content-neutral can nonetheless be unconstitutional if they prohibit too much speech. *See City of Ladue v. Gilleo*, 512 U.S. 43, 55 (1994) (finding content-neutral regulation of yard signs unconstitutional because it "foreclose[s] an entire medium of expression"); *Lovell v. Griffin*, 303 U.S. 444, 451 (1938) (finding ordinance unconstitutional that prohibited distribution of all magazines and pamphlets).

Here, and most importantly, Dr. Sell has an interest in his own thought process that is separate and distinct from his right to communicate those thoughts to others. The government's efforts are directed to changing the manner in which Dr. Sell thinks. The restriction is pre-content. As this Court has found: "First Amendment freedoms are most in danger when the government seeks to control thought or to justify its laws for that permissible end." *Ashcroft*, 122 S. Ct. at 1403. None of the cases cited by the government allow it to limit what and how an individual thinks. Rather, "[o]ur whole constitutional heritage rebels at the thought of giving government the power to control men's minds." *Stanley*, 394 U.S. at 565. Dr. Sell has a fundamental, First Amendment right to avoid forced medication aimed at changing the way he thinks.

II. THE GOVERNMENT'S INTEREST IN BRINGING DR. SELL TO TRIAL FOR NON-VIOLENT CRIMES DOES NOT OVERRIDE DR. SELL'S FUNDAMENTAL RIGHT.

Once the Court determines that Dr. Sell's right to refuse unwanted drugs is fundamental, the government must prove by clear and convincing evidence that its interest is compelling enough to overcome the fundamental right and

that it is using reasonable and the least restrictive means to accomplish its goal. Application of a strict scrutiny approach ensures that the government will only attempt to drug individuals in extraordinary cases. Under strict scrutiny, the prosecution of an individual for a non-violent crime, involving only economic loss, must never be adjudged compelling enough to overcome the individual's right to refuse unwanted drugging. Even in advocating for its own interest, the only harm alleged and articulated by the government in the instant case is "draining an important federal assistance program of its limited resources." Government's Brief at 24.

This justification for forced drugging of Dr. Sell is unavailing. First, only six of the 63 counts of the indictment regard allegations that Dr. Sell submitted improper invoices to a federal program. *Id.* at 23. The remainder govern transactions involving private insurance companies. *Id.* Second, to the extent that the government wants to obtain a monetary award to reimburse the federal government, it can pursue this interest by seeking a civil monetary award. *See* 42 U.S.C. § 1320a-7a(a)(1)(A); FED. R. CIV. P. 17(c). Likewise, the private insurers would presumably have civil remedies at their disposal. Although the government certainly has an interest in protecting the financial integrity of its institutions, this interest is not compelling enough to justify the forced drugging of Dr. Sell.

Further, our constitutional heritage recognizes that an individual's liberty or other interests are often protected to the detriment of the government's prosecutorial interests. *Cooper v. Oklahoma*, 517 U.S. 348, 354 (1996) (recognizing that government cannot bring an incompetent individual to trial); *Mapp v. Ohio*, 367 U.S. 643, 659 (1961) (finding that exclusionary rule applies even if its application results in an inability to prosecute); *Greenwood v. United States*, 350

U.S. 366, 375 (1956) (recognizing that "federal authority to prosecute" is not frustrated by use of treatment and commitment statute). This Court has likewise repeatedly recognized that the government's prosecutorial motives are insufficient to justify significant intrusions into an individual's body. *See Ferguson v. Charleston*, 532 U.S. 67, 86 (2001); *Winston v. Lee*, 470 U.S. 753, 767 (1985); *Rochin*, 342 U.S. at 171-74. The government interest is even less important in the instant case, where Dr. Sell has already served more time on the insurance fraud charges than if he had been convicted, where there are doubts about whether Dr. Sell will ever be restored to competency, and when there are concerns that Dr. Sell will not receive a fair trial if drugged into some type of synthetic competency.

The government's suggestion that being charged with any felony creates an interest sufficient to drug an individual highlights why individual liberty interests need the highest level of protection against government intrusion. Thus, under the government approach, its interest in prosecuting an individual for the first-time theft of a single letter would be enough to overcome a person's fundamental interest. *See* 18 U.S.C. § 1708 (establishing a felony for theft of mail).

Further, the government's assertion that every felony constitutes a crime serious enough to justify altering an individual's brain chemistry can be dispelled simply by reviewing some of the felonies with which individuals can be charged. *See* 18 U.S.C. § 2342 (shipment of contraband cigarettes is a felony); § 152 (concealment of item from bankruptcy estate assets is a felony); § 248 (second offense of blocking entrance to abortion clinic is a felony); § 541 (misrepresenting the weight of an imported item is a felony); § 1231 (transportation of strike breakers is a

felony); § 1302 (mailing of a lottery ticket is a felony); § 1368 (causing serious bodily injury to a police dog or horse is a felony); § 1706 (injuring a mail pouch is a felony). Drugging for every crime must not be sanctioned.

Importantly, the government's interest is lessened even further because the record establishes that Dr. Sell is not dangerous. In supporting its argument regarding the importance of its interest, the government has relied almost exclusively on cases in which an individual has been determined to be a danger or potential danger to himself or others. *See Harper*, 494 U.S. at 227; *United States v. Salerno*, 481 U.S. 739, 751-52 (1987). Both the District Court and Court of Appeals below have determined that Dr. Sell does not pose such a danger. (App. 349, 363). Any attempt to imply that Dr. Sell poses a danger to himself or others is simply unsupported by the record and is not a valid consideration when determining the government's interest in forcibly medicating Dr. Sell. (App. 349, 363). Indeed, the question posed by this Court acknowledges that the government wants to medicate Dr. Sell "solely to render him competent."

Further, because the record indicates a strong disagreement about the side effects of antipsychotic medication and whether medication is even an appropriate treatment for delusional disorder, persecutory type, the government's interest should not supersede Dr. Sell's individual rights. As this Court has recognized: "The individual should not be asked to share equally with society the risk of error when the possible injury to the individual is significantly greater than any possible harm to the state." *Addington v. Texas*, 441 U.S. 418, 427 (1979). The government has not shown that its interest is compelling enough to override Dr. Sell's fundamental right.

III. THE GOVERNMENT HAS NOT SHOWN THAT THE FORCED MEDICATION OF DR. SELL IS A REASONABLE AND LEAST RESTRICTIVE MEANS OF ACCOMPLISHING ITS INTEREST.

Involuntarily drugging Dr. Sell is not the least restrictive means of accomplishing the government's interest.[4] The government admits that, even though Dr. Sell has been confined for five years, it has not attempted any other method to restore Dr. Sell's competency. At the hearing, DeMeir testified that Dr. Sell was not receiving any treatment for his condition and that he was being kept in solitary confinement, which may be exacerbating his illness. (App. 180, 188). The government's refusal to consider any less restrictive means is highlighted by the anonymous, uncited authority presented in its Response Brief, which claims that in a recent twelve-month period 285 pretrial detainees, who were deemed incompetent to stand trial, were evaluated and treated by the Bureau of Prisons. Government's Brief at 27. Of these 285 individuals, 226 were voluntarily drugged and 59 were involuntarily drugged. Thus, the government drugged 100% of the people it evaluated. It has not tried to treat Dr. Sell as suggested by Dr. Sell's expert physician/psychiatrist Dr. Cloninger. (App. 32).

The government argues that medication is the least restrictive means because Dr. Sell will only be medicated for a short period of time. *See, e.g.*, Government's Brief at

[4] Even if the Court finds that drugging Dr. Sell is the only means of accomplishing the government's interest, this Court has recognized that in some circumstances, even use of the least restrictive means is not constitutionally permissible. *United States v. Playboy Entm't Group, Inc.*, 529 U.S. 803, 813 (2000).

33. It must be noted that once Dr. Sell is drugged, his right to avoid the drugging has been infringed. Moreover, the articles cited by the government recognize that severe dyskinesia sometimes results from the withdrawal of antipsychotic drugs. Stanley N. Caroff, et al., *Movement Disorder Associated with Atypical Antipsychotic Drugs*, 63 J. CLIN. PSYCHIATRY 12, 15 (2002). Studies have also shown that short treatments with antipsychotic drugs may not be sufficient to effectuate changes in patients with delusional disorders. Alan R. Felthous, et al., *Are Persecutory Delusions Amenable to Treatment*, 29 J. AM. ACAD. PSYCHIATRY LAW 461, 465 (2001). Ironically, the government's proposed "least restrictive alternative" contemplates that if the drugs given to make Dr. Sell competent create prejudicial side effects, then he should be subjected to further unwanted medication to counteract those side effects. *See, e.g.*, Government's Brief at 33. This never-ending cycle of medication is not reasonable. Here, the "least restrictive" method is also the most restrictive; Dr. Sell's rights and the government's stated interest cannot co-exist.

The inquiry is whether the government's proposed action is the least restrictive means *of accomplishing the government's interest*. *Playboy Entm't Group*, 529 U.S. at 813. The government's interests can be met in several, other less restrictive ways. As Justice Kennedy recognized in *Riggins*, the government can attempt to civilly commit Dr. Sell until he is competent to stand trial. *Riggins v. Nevada*, 504 U.S. 127, 145 (1992). Given the economic nature of the crimes, the government may also seek civil penalties and damages for any claimed monetary losses. *See* 42 U.S.C. § 1320a-7a(a)(1)(A).

The government must prove by clear and convincing evidence that its proposed solution will accomplish the

government's goals. Even if the government's statistics are to be believed, there is a 24% chance that Dr. Sell will not be restored to competency. As discussed in section IV(B), *infra*, even if Dr. Sell were made competent, the government has not shown that the side effects of the drugs will not impermissibly interfere with Dr. Sell's constitutional, fair trial rights. The government has not shown that medicating Dr. Sell is the least restrictive means of accomplishing its objective or that the medication of Dr. Sell will accomplish the government's goal of bringing him to trial.

IV. THE GOVERNMENT CANNOT SATISFY ITS OWN FOUR-PART TEST.

The four-part test proposed by the government does not pass constitutional muster because it does not comport with the dictates of strict scrutiny. However, even if it were constitutionally appropriate to adopt the four-part test proposed by the government, it has failed to meet the elements of its own test. From the outset, the government cannot establish that drugging Dr. Sell is an essential state interest. In any case, the government suggests that forced medication of a pretrial detainee is appropriate when the government can demonstrate that (1) the medication has a substantial probability of restoring competence; (2) the medication is medically appropriate; (3) there is no reasonable and less intrusive alternative;[5] and (4) it is reasonable to expect that the defendant, if restored

[5] As discussed in section III, *supra*, the government is unable to establish that its decision to drug Dr. Sell is reasonable and that it is the least intrusive way to accomplish its objectives.

to competency, will receive a fair trial. Government's Brief at 15. These factors are not met in this case.

A. The Government Has Not Shown That Any Medication Will Restore Dr. Sell To Competence Or That It Is Medically Appropriate.

The government has not shown by clear and convincing evidence that "the medication" or any medication has a substantial probability of restoring Dr. Sell to competence or that such medication is medically appropriate. As a matter of fairness, such findings require, at a minimum, that the government provide Dr. Sell and the court with the medications with which it plans to medicate him. Without this information, Dr. Sell is left to rebut the government's vague and generalized assertions about the effects of dozens if not hundreds of antipsychotic drugs on a myriad of different psychiatric conditions, which are unlike Dr. Sell's rare psychiatric condition.

Recognizing that the government's evidence regarding the efficacy and medical appropriateness of non-specific medication was tentative at best, the government now floods the Court with facts, statistics, and non-legal authorities not found in the Record. *See, e.g.*, Government's Brief at 27, 28 n.8, 29-34, 34 n.9, 35, 39-41, 45-46. At times, the government relies upon facts and statistics without citation. *See, e.g.*, Government's Brief at 27, 39. For example, while arguing that antipsychotic medication will restore Dr. Sell's competency, the government relies upon statistics emanating from "the experience of the Bureau of Prisons" without citation. Government's Brief at 27. Moreover, many of the authorities the government cites *did not even exist* at the time of the involuntary medication hearing. *See, e.g.*, Government's Brief at 27, 30,

32, 34, 34 n.9, 35, 39, 41, 45 (relying upon authorities dated 2000, 2001, or 2002). This Court should not entertain such material, as Dr. Sell had no opportunity to rebut any of this material and none of this information was presented to any lower court for consideration.[6]

Instead of allowing the government to submit to this Court information outside the Record, "the lawfulness of [the lower court's actions regarding] the defendant is to be determined *by the formal record*. . . . " *Hoyt v. People*, 114 U.S. 488, 491 (1885) (emphasis added) (rejecting affidavit). It has been this Court's practice to reject information which is unaccounted-for and to which the opposing party has not been able to respond. *See Adickes v. S.H. Kress & Co.*, 398 U.S. at 157-58 n.16 (1970); *see also Russell v. Southard*, 53 U.S. (12 How.) 139, 158-59 (1851) (Taney, C.J.) (rejecting motion to receive affidavits of newly-discovered evidence). This Court must rule "upon the case as it appears in the record . . . [and] cannot look out of it. . . . " *Id.* at 159; *see also Witters v. Wash. Dep't of Servs. for the Blind*, 474 U.S. 481, 486-87 n.3 (1986) (noting importance of "factual development in earlier proceedings"); *New Haven Inclusion Cases*, 399 U.S. 392, 450 n.66 (1970) ("None of this is record evidence, and we do not consider it."). In *Adickes*, the respondent lodged with this Court an unsworn statement, but this Court recognized the impropriety of such a maneuver, since "the statement itself is not in the record of the proceedings below and

[6] The government's uncited reference to such statistics is additionally deficient due to the otherwise vague manner in which the government refers to them, since the government has provided no identifying information which would allow Petitioner to rebut such statistics. *See* Government's Brief at 27 ("Over a recent twelve month period").

therefore could not have been considered by the trial court." 398 U.S. at 157-58 n.16. The government's reliance upon non-legal authorities not before the lower courts is likewise improper.

Importantly, the bulk of the new sources the government attempts to interject are not helpful to the consideration of the case because these sources deal with the appropriateness of medication for schizophrenia.[7] Schizophrenia is a separate and distinct condition from delusional disorder, the affliction from which Dr. Sell's suffers. (App. 257; Record 766). At points in its Brief, the government weaves into its discussion of Dr. Sell's condition, delusional disorder, (App. 226), specific references to schizophrenia and suitable treatment therefor. Government's Brief at 30 ("[s]chizophrenia is characterized by profound disruption in cognition and emotion") (citation omitted). At other points in its Brief, the government's efforts are more subtle, such as where it indicates Geodon – a drug the FDA approved only for schizophrenia, *see* Federal Drug Administration, FY 2001 User Fee NME Approvals as of September 30, 2001, http://fda.gov/cder/rdmt/FYUFNME2001Rel.htm. – would be suitable for treating Dr. Sell's delusional disorder. Further, the government's own sources recognize that it is improper to assume that

[7] Stanley N. Caroff, et al., *Movement Disorder Associated with Atypical Antipsychotic Drugs*, 63 J. CLIN. PSYCHIATRY 12, 12 (2002) (stating atypical drugs are a significant advance in treatment of schizophrenia); Linda Pendleton, Ph.D., *Treatment of Persons Found Incompetent to Stand Trial*, 137 AM. J. PSYCHIATRY 1098-99 (1980) (noting 90% of patients in 1978 study group had schizophrenia); National Institute of Mental Health, Mental Health: A Report of the Surgeon General 279-80 (1999) (pages cited in Government's Response concern schizophrenia).

patients with delusional disorder will respond to medications in the same way as those with schizophrenia. Felthous, *supra*, at 463 (2001) (recognizing "paranoid patients are usually very sensitive to all side effects of drugs" (citation omitted)).

The government's repeated references to and heavy reliance upon facts, statistics, and authorities not in the Record attempt to indicate a well-developed body of literature regarding antipsychotic drugs' appropriateness in treating delusional disorder.[8] As demonstrated by the amicus briefs, there remains medical debate between the nation's largest organization of psychiatrists and the largest organization of psychologists about whether medication is appropriate treatment for delusional disorder, persecutory type. In its amicus brief, the American Psychological Association stated: "At present, there is no consensus among researchers that delusional disorder, persecutory type will respond favorably to antipsychotic drugs. . . . " American Psychological Association Brief at 17 (citing sources). Likewise, the District Court recognized

[8] Even were the alleged developments upon which the government relies certain to occur following the involuntary medication hearing, this Court cannot lend serious weight to the claim that the lower courts should have predicted such changes and acted according to events not on the record. *See Ramdass v. Angelone*, 530 U.S. 156, 178 (2000) (denying habeas relief due to record before court at time of sentencing and rejecting argument that subsequent developments that might have altered jury verdict were "inevitable" at time of sentencing). This Court has previously evaluated the status of science from the time the case was before the district court, *see Reno*, 521 U.S. at 876-77 (evaluating technology from time of trial), and has relied upon scientific and technological developments only once those developments actually occurred, *see Ashcroft v. ACLU*, 122 S. Ct. 1700, 1704 (2002).

the current debate among experts about whether medication is effective to treat delusional disorder, persecutory type.[9] Even the sources cited by the government recognize "[t]here have been no controlled studies of specific agents in the treatment of delusional disorder." Felthous, *supra*, at 461. Given this debate and the government's refusal to name the medications and dosages it plans to use, the government cannot establish by clear and convincing evidence that Dr. Sell will be restored to competence or that medication is medically appropriate.

B. It Is Not Reasonable To Expect That Dr. Sell, If Restored To Competency, Will Receive A Fair Trial.

The government argues that, before medicating Dr. Sell, it should be required to prove that it is reasonable to expect that the defendant, if restored to competency, will receive a fair trial. The government ignores that it was not required to make this showing before either the District Court or the Court of Appeals. The District Court found that consideration of the issue was premature. (App. 352). Further, the Court of Appeals did not ask whether Dr. Sell would receive a fair trial. Rather, the Court of Appeals

[9] In a recent *en banc* opinion, four members of the Eighth Circuit Court of Appeals, two of whom were on the three judge panel in *United States v. Sell*, found that drugging with antipsychotic drugs produces a synthetic sanity, which is temporary and unpredictable and that "receiving treatment is not synonymous with being cured." *Singleton v. Norris*, No. 00-1492, 2003 WL 261795, at *14 (8th Cir. Feb. 10, 2003) (Heaney, J., dissenting). These judges also recognized that "[a]ntipsychotic drugs merely calm and mask the psychotic symptoms which usually return to debilitate the patient when the medication is discontinued." *Id.* (citation omitted).

considered only whether Dr. Sell would be able to participate in a trial, given the effects of the medication. The Court of Appeals, therefore, did not consider whether the medication would effect Dr. Sell's trial rights, including the right to present a diminished capacity defense, *see* FED. R. CRIM. P. 12.2(b), the right to not have the government manipulate his appearance in a way that prejudices him before the jury, and the right to testify and "present his own version of events in his own words." *Rock v. Arkansas*, 483 U.S. 44, 52 (1987); *see also Illinois v. Allen*, 397 U.S. 377, 345 (1970); FED. R. CRIM. P. 12.2(b).

Further, the lower courts could not have made a determination that there is a substantial probability that Dr. Sell will receive a fair trial. The government has not provided Dr. Sell or the lower courts with the medications or dosages it intends to use with Dr. Sell. A general review of the effects of non-specific medications on individuals who suffer from a wide-range of psychological conditions is not sufficient to protect Dr. Sell's rights.

Importantly, our nation's constitutional heritage does not countenance the drug first, hold a hearing second approach advocated by the government. Rather this Court has made clear that due process requires at a minimum that, when possible, an individual be given notice and the right to a hearing before the deprivation of a right. *United States v. James Daniel Good Real Property*, 510 U.S. 43, 57 (1993). If the forced medication of a non-dangerous individual is even constitutionally permissible, due process requires that the Court consider the full effects of a deprivation on the defendant's trial rights before the right is taken away, not afterward.

Given the numerous effects medication will have on Dr. Sell's trial rights, the government cannot show that

forced medication would constitute harmless error. Contrary to the government's suggestion, Dr. Sell has never argued that he has a right to appear incompetent at trial. Rather, Dr. Sell has a right to appear at trial in a state that is unmanipulated by the government. Defendants may not be required to appear before the jury in prison garb, in shackles, or in an unkempt state, absent the most compelling interest. *Allen*, 397 U.S. at 344 . Likewise, the government may not inject Dr. Sell with antipsychotic drugs, then inject him with another round of drugs to counteract the antipsychotic drugs, and then place him before the jury in a state of synthetic sanity.

Further, Dr. Sell is the best witness regarding the effects of the drugs on his thinking and demeanor. Once the government manipulates Dr. Sell's brain, Dr. Sell loses his best witness regarding the effects of the medication on his ability to think and communicate. Dr. Sell has no way of preserving his pre-medication demeanor or beliefs in a manner that would be accepted as evidence by the court without waiving his right to take the Fifth Amendment. Dr. Sell will be faced with a Hobson's choice: waive his Fifth Amendment right to attempt to explain to the jury the effects of the forced medication or refuse to testify and risk that the jury is still improperly affected by these same considerations.

Importantly, a predeprivation review of Dr. Sell's Fifth and Sixth Amendment trial rights is vital to the consideration of whether the government's interest in overriding Dr. Sell's First and Fifth Amendment rights is compelling. Since it is unlikely that Dr. Sell will both regain competence and then have a fair trial after being medicated, the government's interest in drugging Dr. Sell is severely diminished and cannot be deemed compelling.

CONCLUSION

For the foregoing reasons, Dr. Sell respectfully requests that the Court rule that forced administration of antipsychotic drugs for the sole purpose of prosecuting him for a non-violent crime violates his First, Fifth, and Sixth Amendment rights.

Respectfully submitted,

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AUG 19 2002

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IN THE

Supreme Court of the United States

Dr. Charles Thomas Sell, D.D.S.
Petitioner,

v.

United States of America,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF *AMICUS CURIAE* OF THE CENTER FOR COGNITIVE LIBERTY & ETHICS IN SUPPORT OF THE PETITION FOR CERTIORARI

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I.
INTEREST OF AMICUS CURIAE

With the written consent of the parties reflected in letters lodged with the Clerk, undersigned counsel for the Center for Cognitive Liberty & Ethics (CCLE), submits this brief as *amicus curiae* in support of petitioner pursuant to Rule 37 of the Rules of Court.[1]

The CCLE is a nonprofit education, law, and policy center working in the public interest to foster cognitive liberty—the right of each individual to think independently, to use the full spectrum of his or her mind, and to have autonomy over his or her own brain chemistry. The CCLE encourages social policies that respect and protect the full potential and autonomy of the human intellect. The CCLE was an *amicus curiae* party to this case, on behalf of petitioner Dr. Sell, when Petition for Rehearing/Rehearing en banc was filed before the Eighth Circuit below.

As an organization charged with defending freedom of thought, the CCLE has a vital interest in this case because the forcible injection of a citizen with a mind-altering drug directly infringes on cognitive liberty and mental autonomy.

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[1] No counsel for a party authored this brief in whole or part, and no person or entity other than the *amicus curiae*, its members or its counsel, made a monetary contribution to the preparation and submission of this brief.

The CCLE is deeply concerned that the decision below seriously compromises the core of the First Amendment and, if permitted to stand, will undermine the fundamental right of all citizens to have autonomy over their own minds and mental processes.

In particular, the CCLE seeks to assist the Court by demonstrating that the right at stake in this case is a fundamental First Amendment right. The CCLE seeks to show that more is at issue in this case than what courts have commonly termed "bodily integrity." At stake is an even more fundamental right, one which combines the liberty interest in bodily integrity with the fundamental right to freedom of thought. This combined right the CCLE terms "cognitive liberty."

Correctly characterizing the liberty interest at stake in this case is critical for determining the standard of review to be applied in this case and in similar cases in the future.

SUMMARY OF ARGUMENT

The CCLE submits that the court of appeals mischaracterized the fundamental right at issue in this case, and as a result, erred by applying an inappropriately low standard of review.

The fundamental right to control one's own intellect and mental processes is protected by the First Amendment, and is eviscerated if courts permit the government to forcibly drug citizens. If government agents, with the concurrence of the courts, can constitutionally order the forcible manipulation of Dr. Sell's mind in order that he may stand trial, then any accused defendant, who poses no danger to himself or others, is also at jeopardy of losing his or her First Amendment right to freedom of thought.

To be sure that our argument is correctly understood, the CCLE does not propose that the state cannot regulate the *behavior* of individuals, including the acts of individuals who are incoherent or who spit on, or otherwise assault, judges. We maintain that the state cannot, consistent with the First Amendment of the Constitution, forcibly manipulate the *mental states* of individuals.

ARGUMENTS

I. Freedom of Thought and Cognitive Liberty are Fundamental Rights Guaranteed by the First Amendment.

In declaring that the state may forcibly inject a nondangerous citizen with mind-altering drugs in order to make him "competent to stand trial," the Eighth Circuit's decision goes far beyond *any* holding of this Court

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concerning the right of the state to directly intrude into the mind of a citizen. The sweeping breadth of the Eighth Circuit's decision places freedom of thought in dire jeopardy, calling into question not only the Sixth Amendment right to a fair trial, but the very foundation of the First Amendment, including basic notions of individual freedom upon which this country was founded.

The CCLE submits that more than the defendant's liberty interest in bodily integrity is at stake in this case. Here, the state seeks to forcibly invade a nondangerous pretrial detainee's body and manipulate his brain chemistry *for the purpose of changing how he thinks*.[2] In other words, this case combines the issue of bodily integrity with the issue of freedom of thought, and thus raises what the CCLE terms a "cognitive liberty" issue.

While the Eighth Circuit acknowledged that Dr. Sell has a "significant liberty interest in refusing anti-psychotic medication" *United States v. Sell*, 282 F.3d 560, 568 (2002), the court grossly undervalued the individual interest at stake in this case. The right to freedom of thought is far more than

[2] This Court has described "antipsychotic" drugs as medications with the purpose "to alter the chemical balance in a patient's brain, leading to changes...in his or her cognitive processes." *Washington v. Harper*, 494 U.S. 210, 229 (1990). In his concurring opinion in *United States v. Riggins*, Justice Kennedy described antipsychotic drugs as "medications [that] restore normal thought processes...." *United States v. Riggins*, 504 U.S. 127, 141 (1992) (Kennedy, J., concurring).

"significant;" it is situated at the very core of what it means to be a free person in a civilized society, and is a fundamental right protected by the First Amendment.

The First Amendment to the United States Constitution, which Professor Laurence Tribe has called "the Constitution's most majestic guarantee,"[3] provides:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances. (U.S. Const. Amend. I.)

This Court has noted that while "[t]he First Amendment literally forbids the abridgment only of "speech," ... we have long recognized that its protection does not end at the spoken or written word." *Texas v. Johnson*, 491 U.S. 397, 404 (1989); *see also, Globe Newspaper Co. v. Superior Court*, 457 U.S. 596, 604 (1982) ("[W]e have long eschewed any 'narrow, literal conception' of the [First] Amendment's terms, ...for the Framers were concerned with broad principles....").

This Court has repeatedly observed that there are derivative and corollary rights that are essential to effectuate

[3] Laurence Tribe, *American Constitutional Law*, Sec. 12-1, p. 785 (2nd ed. 1988).

the purposes of the First Amendment, or which are inherent in the rights expressly enumerated in the Amendment. For example, in *Lamont v. Postmaster Gen.*, 381 U.S. 301, 308 (1965), Justice Brennan, in his concurring opinion explained:

> It is true that the First Amendment contains no specific guarantee of access to publications. However, the protection of the Bill of Rights goes beyond the specific guarantees to protect from congressional abridgement those equally fundamental personal rights necessary to make the express guarantees fully meaningful.

Likewise, in *Globe, supra,* this Court observed that "[t]he First Amendment is thus broad enough to encompass those rights that, while not unambiguously enumerated in the very terms of the Amendment, are nonetheless necessary to the enjoyment of other First Amendment rights." *Globe, supra*, 457 U.S. 596, 604. In 1982, this Court employed this reasoning to recognize a "right to receive information and ideas," locating the right as "an inherent corollary of the right of free speech and press" guaranteed by the First Amendment. *Board of Educ. v. Pico*, 457 U.S. 853, 867 (1982) (plurality opinion).

Freedom of thought, while not expressly guaranteed by the First Amendment is one of the equally fundamental rights necessary to make the express guarantees meaningful. As Justice Benjamin Cardozo extolled, "...freedom of thought...one may say...is the matrix, the indispensable condition, of nearly every other form of freedom. With rare aberrations a pervasive recognition of that truth can be traced in our history, political and legal." *Palko v. Connecticut,* 302 U.S. 319, 326-327 (1937).

Repeatedly, this Court has recognized that freedom of thought is one of the most elementary and important rights inherent in the First Amendment.

In *West Virginia State Board of Education v. Barnette*, 319 U.S. 624 (1943), this Court invalidated a school requirement that compelled a flag salute on the ground that it was an unconstitutional invasion of "the sphere of intellect and spirit which it is the purpose of the First Amendment to our Constitution to reserve from official control." *Id.* at 642. The First Amendment, declared this Court, gives a constitutional preference for "individual freedom of mind" over "officially disciplined uniformity for which history indicates a disappointing and disastrous end." *Id.* at 637. At the center of our American freedom, is the "freedom to be intellectually and spiritually diverse." *Id.* at 641. "We can have intellectual individualism and the rich cultural diversities that we owe to exceptional minds," this Court explained, "only at the price of occasional eccentricity and abnormal attitudes." *Id.* at 641-42.

This principle, that freedom of thought is central to the First Amendment and protected thereby, has guided other important decisions of this Court. In *Wooley v. Maynard*, 430 U.S. 705 (1977), the Court invalidated a New Hampshire statute that required all noncommercial vehicle license plates to bear the state motto "Live Free or Die," finding the statute to be inconsistent with "the right of freedom of thought protected by the First Amendment." *Id.* at 714.

In *Abood v. Detroit Board of Education*, 431 U.S. 209 (1977), this Court invalidated a state statute forcing public school teachers to contribute money to a union that advanced political views. "[A]t the heart of the First Amendment," noted this Court, "is the notion that an individual should be free to believe as he will, and that in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State." *Id.* at 234-235. This Court emphasized, "freedom of belief is no incidental or secondary aspect of the First Amendment's protections." *Id.* at 235.

In the instant case, the government is seeking to directly manipulate and modify Dr. Sell's thoughts and thought process by forcing him to take mind-altering "antipsychotic" drugs. This case thus concerns what the CCLE terms a "cognitive liberty" interest, an interest forged by the union of Dr. Sell's liberty interest in bodily integrity with his First Amendment right to freedom of thought. If "at the heart of the First Amendment is the notion that in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State" (*Abood, supra*, at 234-235), then there can be no doubt that the government infringes on the First Amendment when it seeks to change Dr. Sell's thinking by forcibly changing his brain chemistry.

By altering a person's mind with the forced administration of drugs, the government commits an act of *cognitive* censorship and mental manipulation, an action surely more disfavored under the First Amendment than even the censorship of speech. A government that is permitted to manipulate a citizen's consciousness at its very roots—by forcing a person to take a mind-altering drug—need not censor speech, because it could prevent the ideas from ever occurring in the mind of the speaker. Chemical manipulation of the mind is, therefore, the ultimate prior restraint on speech.[4]

By forcing Dr. Sell to take a mind-altering drug against his will, the government is commandeering Dr. Sell's mind, and forcibly changing his very ability to formulate particular thoughts. By directly manipulating the manner in which Dr.

[4] "Any prior restraint on expression comes to…[the] Court with a 'heavy presumption' against its constitutional validity." *Organization for a Better Austin v. Keefe*, 402 U.S. 415, 419 (1971) (quoting *Bantam Books, Inc. v. Sullivan*, 372 U.S. 58, 70 (1963).

Sell's brain processes information and formulates ideas, the government *ipso facto* manipulates and alters both the form and content of Dr. Sell's subsequent expression and thus renders the First Amendment's free speech guarantee meaningless. "The guarantee of free expression," notes Professor Tribe, "is inextricably linked to the protection and preservation of open and unfettered mental activity..." Laurence Tribe, *Rights of Privacy and Personhood*, American Constitutional Law, Sec. 15-7, at 1322 (2nd ed. 1988).[5]

In *Stanley v. Georgia*, 394 U.S. 557 (1969), this Court struck down a Georgia law that banned the private possession of obscene material for personal use, finding the law "wholly inconsistent with the philosophy of the First Amendment." *Id.* at 565-66. "Our whole constitutional heritage," explained this Court, "rebels at the thought of giving government the power to control men's minds." *Id.* at 565.

[5] Professor Emerson, a leading First Amendment scholar, makes the same point as Professor Tribe. Situating freedom of thought within the First Amendment, Professor Emerson explains:

> Belief...is not strictly "expression." Forming or holding a belief occurs prior to expression. But it is the first stage in the processes of expression, and it tends to progress into expression. Hence safeguarding the right to form and hold beliefs is essential in maintaining a system of freedom of expression. Freedom of belief, therefore, must be held included within the protection of the First Amendment. T. Emerson, *The System of Freedom of Expression* 21-22 (1970).

Justice Harlan, concurring in *United States v. Reidel*, 402 U.S. 351 (1971), characterized the Constitutional right protected in *Stanley* as "the First Amendment right of the individual to be free from governmental programs of thought control, however such programs might be justified in terms of permissible state objectives," and as the "freedom from governmental manipulation of the content of a man's mind...." *Id.* at 359 (Harlan J., concurring).

It is impossible to reconcile a First Amendment aversion to "giving government the power to control men's minds" (*Stanley, supra*) with the actions intended by the government in the instant case. Indeed, it is difficult to imagine a governmental action more offensive to the First Amendment's protection of freedom of thought, than the government forcibly injecting a nondangerous citizen with a mind-altering drug. If, as Justice Harlan explained in *Reidel*, there is a "First Amendment right of the individual to be free from governmental programs of thought control," then that right is clearly at stake in this case.

The Eighth Circuit's decision failed to recognize that the government's action in the instant case infringes on Dr. Sell's First Amendment right to freedom of thought. Forcibly injecting Dr. Sell with a mind-altering drug infringes on one of the most primary rights imaginable: the right to cognitive liberty and autonomy. This Court should grant the petition in

order to articulate the fundamental First Amendment nature of Dr. Sell's right to cognitive liberty.

Vigorous protection of cognitive liberty is particularly important today, as pharmaceutical companies increasingly develop and market new drugs aimed at modulating consciousness by modifying brain chemistry. The sale of Prozac™ and similar antidepressant drugs is currently one of the most profitable segments of the pharmaceutical drug industry. According to IMS Health, a fifty-year-old company specializing in pharmaceutical market intelligence and analyses, "antidepressants, the #3-ranked therapy class worldwide, experienced 18 percent sales growth in 2000, to $13.4 billion or 4.2 percent of all audited global pharmaceutical sales."[6] Sales of "anti-psychotic" drugs are currently the eighth largest therapy class of drugs with worldwide sales of $6 billion in the year 2000, a 22 percent increase in sales over the previous year.[7]

[6] IMS Health, *Antidepressants*, a summary of which is available online at: http://www.imshealth.com/public/structure/navcontent/1,3272,1034-1034-0,00.html.

[7] See IMS Health, *Antipsychotics*, a summary of which is available online at: http://www.imshealth.com/public/structure/navcontent/1,3272,1035-1035-0,00.html. A report published by the Lewin Group in January 2000, found that in 1998, antidepressants and antipsychotics accounted for 9% of Medicaid prescriptions. The same report found that within the Medicaid program alone, "Antidepressant prescriptions totaled 19 million in 1998...[and] [a]ntipsychotic prescriptions totaled 11 million in 1998." (Lewin Group, *Access and Utilization of New Antidepressant and Antipsychotic Medications* (Jan. 2000), prepared under contract for the

While the development of such drugs is to be applauded for their potential to aid millions of suffering Americans who *voluntarily* take them, the instant case raises the chillingly dark prospect of the government *forcibly* employing these new drugs to chemically alter the way that certain people think.[8]

The instant case thus raises significant theoretical constitutional issues with enormous practical implications. In the context of the ever-increasing ability to pharmacologically intervene in the minds of Americans, this case presents the Court with the timely and extremely important opportunity to articulate some unequivocal rules that respect freedom of thought and cognitive liberty. The CCLE

Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation, and The National Institute for Mental health, Department of Health and Human Services. Available online at: http://aspe.hhs.gov/health/reports/Psychmedaccess/

According to Datamonitor, "Antidepressants have become a key focus for pharmaceutical manufacturers due to the huge growth in the market instigated by the launch of Prozac™ in the 1980s. Due to their expansion into new markets away from depression, the therapy class is now valued at $14bn and is set to continue expanding despite the upcoming patent loss of numerous key products." Datamonitor, *Market Dynamics 2001: Antidepressants*, Report - DMHC1725 (Dec. 21, 2001). Datamonitor forecasts that the demand for antidepressants will continue to grow, and estimates the market value to reach $18.3 billion by 2008. Ibid.

[8] The former Soviet Union had no First Amendment equivalent. It was not uncommon for prison psychiatrists to forcibly drug political dissidents after labeling them "mentally ill." *See*, Sidney Bloch & Peter Reddaway, *Psychiatric Terror: How Soviet Psychiatry Is Used to Suppress Dissent* (1977); Clarity, *A Freed Dissident Says Soviet Doctors Sought to Break His Political Beliefs*, New York Times (Feb 4, 1976) A1, 8.

respectfully urges this Court to grant the petition for certiorari.

II. Government Action that Substantially Infringes Upon the First Amendment Right to Cognitive Liberty Should, at the Very Least, be Subject to Strict Scrutiny.

Forcing a nondangerous pretrial detainee to take a mind-altering drug violates the First Amendment right to cognitive liberty. The forcible administration of so-called "anti-psychotic" medication is not an effort to control a person's behavior, with merely an incidental effect on the person's thinking. It is an effort aimed *directly* at changing the person's *mind and mental processes*, by forcibly manipulating his or her brain chemistry. Such a government invasion of bodily integrity—one aimed at directly manipulating the person's thoughts and thinking processes—infringes on the First Amendment and must be judged under no less a standard than strict scrutiny.

In reaching its holding that Dr. Sell may be forcibly injected with mind-altering drugs, the court of appeal rejected application of the strict scrutiny standard of review. *Sell, supra*, 283 F.3d at p. 568. In applying a lesser standard of review, the court of appeals misread this Court's decision in *United States v. Riggins*, 504 U.S. 127 (1992), and, ultimately, failed to apply the appropriately strict standard for judging a First Amendment cognitive liberty infringement.

The court of appeals' reliance on *Riggins*, for the proposition that strict scrutiny is not demanded in the instant case, is misplaced. In *Riggins*, this Court expressly refused to determine the standard of review to be applied when a nondangerous pre-trial detainee is force-drugged by the government. "We have no occasion," wrote this Court, "to prescribe such substantive standards...." *Riggins, supra*, 504 U.S. at p. 136.

The instant case provides the Court with an opportunity to articulate the fundamental First Amendment nature of the right to cognitive liberty, and the relationship of this right to a government effort to forcibly modify the brain chemistry of a nondangerous pretrial detainee. The instant case is striking for the factual finding that *Dr. Sell does not pose a danger to himself or to others. Sell, supra*, 283 F.3d at p. 565 ("Upon review, we agree that the evidence does not support a finding that Sell posed a danger to himself or others at the Medical Center"). The sole government interest offered as justification for forcibly drugging Dr. Sell is the state's "interest in bringing a defendant to trial." *Sell, supra*, 283 F.3d at p. 568.

Given that the forced-drugging of Dr. Sell is a direct effort to alter the content and form of his thoughts—the

essential substrate for free speech and expression—the correct standard is strict scrutiny, at the very least. *See N.A.A.C.P. v. Button*, 371 U.S. 415, 438 (1963) ("The decisions of this Court have consistently held that only a compelling state interest...can justify limiting First Amendment freedoms"); *United States v. Brandon*, 158 F.3d 947 (6th Cir. 1998) ("to medicate a non-dangerous pretrial detainee in order to render him competent to stand trial...the government must satisfy strict scrutiny review...").

Applying a lesser standard, as did the Eighth Circuit, was erroneous, and places in substantial jeopardy the fundamental right of all Americans to freedom of thought and cognitive liberty. This Court should grant the petition in order to resolve the current standard of review in light of the fundamental First Amendment right at stake.

CONCLUSION

For the foregoing reasons, *amicus curiae* respectfully urges the Court to grant the petition for certiorari.

Respectfully submitted,

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In The

Supreme Court of the United States

DR. CHARLES THOMAS SELL,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF THE NATIONAL ASSOCIATION OF CRIMINAL DEFENSE LAWYERS AS *AMICUS CURIAE* IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

1. Whether the district court must consider the effects of involuntary medication on a defendant's right to a fair trial prior to ordering the involuntary medication of defendant?

INTEREST OF AMICUS[1]

The National Association of Criminal Defense Lawyers (NACDL) is the preeminent organization in the United States advancing the mission of America's criminal defense lawyers to ensure justice and due process for persons accused of crime or other misconduct. A professional bar association founded in 1958, NACDL's more than 10,400 direct members – and more than 80 state and local affiliate organizations with another 28,000 members – include private criminal defense lawyers, public defenders, active U.S. military defense counsel, law professors, and judges committed to preserving fairness within America's criminal justice system. The America Bar Association recognizes NACDL as an affiliate organization with full representation in its House of Delegates.

NACDL promotes study and research in the field of criminal law to disseminate and advance knowledge of the law in the area of criminal practice. NACDL seeks to defend individual liberties guaranteed by the Bill of Rights and has a keen interest in ensuring that legal proceedings are handled in a proper and fair manner. Among NACDL's objectives is promotion of the proper administration of justice. In furtherance of that objective, over the last

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[1] Pursuant to this Court's Rule 37.2(a), letters of consent from both parties to the filing of this brief have been filed with the Clerk. Pursuant to this Court's Rule 37.6, counsel represent that this brief was not authored in whole or in part by counsel for any party, and that no person or entity other than amicus, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

decade, NACDL has filed approximately ten *amicus* briefs per year with this Court on criminal justice related issues.

SUMMARY OF THE ARGUMENT

Prior to ordering that a defendant may be forcibly injected with anti-psychotic drugs for the sole purpose of restoring the defendant's competency to stand trial, the Court must conduct a pre-medication analysis to determine how the medication will effect defendant's demeanor at trial and his ability to assist his attorney in presenting his defense.

REASONS FOR GRANTING THE WRIT

I. The Petition should be granted to resolve the split of authority on whether a trial court must consider the effects of involuntary medication upon a defendant's right to a fair trial prior to ordering the involuntary medication of defendant.

The Eighth Circuit Court of Appeals has decided the issue of pre-medication analysis contrary to that of the Sixth Circuit Court of Appeals. Here, the Eighth Circuit Court of Appeals held that Dr. Sell's right to a fair trial was not violated because there was evidence that Dr. Sell would be able to participate meaningfully in his trial while under the influence of the medication and that the effects of the medication on his competency and demeanor could properly be considered once the medication was administered. *United States v. Sell*, 282 F.3d 560, 572 (8th Cir. 2002). For those reasons, along with the district court's

willingness to re-examine Dr. Sell's Sixth Amendment claims after the medication regimen had begun, the Eighth Circuit Court of Appeals found Dr. Sell's right to a fair trial adequately protected. *Id.* The Eight Circuit did not, however, consider the effect of the medication upon Dr. Sell's demeanor at trial.

This holding is in conflict with *United States v. Brandon*, 158 F3d. 947 (6th Cir. 1998). In *Brandon*, the Sixth Circuit held that before ordering the involuntary medicating of a defendant, the court must consider the effect of the medication upon the defendant's physical appearance at trial as well as its effects on the defendant's ability to aid in his defense. *Id.* at 955.

This Court has recognized that the involuntary administering of anti-psychotic drugs impinges upon a defendant's right to a fair trial by altering his demeanor and by interfering with his ability to assist his attorney in presenting his defense. *Riggins v. Nevada*, 504 U.S. 127, 142 (1992) (Kennedy, J., concurring). More specifically, compelling a defendant to take psychotropic medication prejudices the defendant and falsifies the jury's impression of the defendant because he may appear emotionally unresponsive, bored, nervous or restless. *Id.* at 143. Our legal system is one in which the trier of fact observes the defendant throughout the trial, whether he is testifying or sitting at counsel table. *Id.* at 142. Forcing medication upon a defendant raises many of the same concerns as if material evidence has been manipulated. *Id.* at 139.

The effect of the medication on Dr. Sell's demeanor was not addressed by the district court or the Eighth Circuit Court of Appeals but was found to be an issue that could be addressed after the medication regimen had

begun. With Dr. Sell's mental state at issue, the jury will undoubtedly observe and scrutinize his demeanor regardless of whether or not he testifies. While the medication may help to restore Dr. Sell's competency, it may at the same time alter or alleviate his symptoms which most likely would convince a jury of his diminished capacity at the time of the offense.

Given the gravity of the issue, and the conflicting holdings on the issue of pre-medication analysis, this Court should grant the petition for writ of certiorari.

CONCLUSION

The writ of certiorari should be granted.

Respectfully submitted,

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BRIEF OF *AMICI CURIAE* THE ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC. AND EAGLE FORUM EDUCATION & LEGAL DEFENSE FUND IN SUPPORT OF PETITIONER

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BRIEF OF *AMICI CURIAE* THE ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC. AND EAGLE FORUM EDUCATION & LEGAL DEFENSE FUND IN SUPPORT OF PETITIONER

INTEREST OF *AMICI CURIAE* [1]

The Association of American Physicians & Surgeons, Inc. ("AAPS") is a non-profit organization dedicated to defending the practice of private medicine. Founded in 1943, AAPS publishes a newsletter, journal and other materials in furtherance of its goals of limited government and the free

[1] This brief is filed with the written consent of all parties. No counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *amici*, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

market. Members of AAPS object to the violation of ethical medicine entailed in the forced drugging of a peaceful prisoner with antipsychotic medication. It is a fundamental principle of medical ethics, and human rights generally, that individuals have the right to decline treatment when they pose no threat to others or themselves. AAPS has a strong interest in protesting the misuse of medicine in violation of this basic principle.

Eagle Forum Education and Legal Defense Fund ("EFELDF") is a nonprofit organization founded in 1981. For over twenty years it has defended principles of limited government and individual liberty which, at a minimum, preclude the federal government from forcibly medicating peaceful individuals against their will. EFELDF is increasingly concerned about public officials compelling citizens to submit to treatment, such as requiring Ritalin or controversial vaccines as a condition of admission to school. EFELDF has a strong interest in restraining government from seizing the power to inject its adversaries with mind-altering drugs.

Amici have a direct and vital interest in the issues presented to this Court based on their representation of physicians and other individuals.

SUMMARY OF ARGUMENT

The decision below created a new federal police power to forcibly drug peaceful citizens presumed to be innocent. This unprecedented power, devoid of any constitutional or statutory basis, is frightening in its potential consequences. It is abjectly inhumane for Petitioner Dr. Sell. Never found guilty of any crime and posing no threat to others, Dr. Sell must submit to forced injection of mind-altering drugs unlimited in quantity and type. *United States v. Sell*, 282 F.3d 560, 565, 571 (8th Cir. 2002). His mental and physical fate is placed entirely in the hands of a single government psychiatrist operating without meaningful oversight.

The Eighth Circuit held that merely by alleging fraud and proffering testimony by a government doctor, a federal prosecutor may alter the mind of a prisoner against his will. The stunning breadth of the decision leaves few, if any, defendants free from the threat of being forcibly subjected to antipsychotic drugs. The decision below set no limits on the type or quantity of the drugs to be injected, allowing even drugs that have not been fully tested and approved for the given purpose. *See* Point II.A, *infra*. This ruling is contrary to every norm of this Court, and Anglo-American jurisprudence.

In so holding, the Eighth Circuit expressly admitted its conflict with the heightened standard of review for drugging adopted by the Sixth Circuit. "[U]nlike the Sixth Circuit, we do not adopt the strict scrutiny standard," the court below held. 282 F.3d at 568. The Eighth Circuit also implicitly rejected heightened standards required by other Circuits and by the logic of this Court.

Manipulation of a peaceful citizen's mind against his will is not an enumerated federal power. The Eighth Circuit has effectively thrust its citizens into a federal experiment unacceptable to the other Circuits. This is not an experiment within the meaning of Justice Brandeis' famous declaration that "a single courageous State may, if its citizens choose, serve as a laboratory." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). No citizens approved this mandatory drugging, and here the federal government rather than a State is doing the experimenting. Mere accusation of regulatory violations, the governmental interest in medicating Dr. Sell to try him, cannot justify alteration of his mind against his will.

Unfortunately, advances in medical technology inevitably facilitate this attempt to expand federal power. Over 50 years ago, George Orwell predicted the misuse of mind-control technology in his famous novel *1984*. There the "persecutor" O'Brien confronts the prisoner with the tool of a hypodermic

syringe, and severe cruelty results. It is uncivilized to authorize a prison doctor to administer, in his sole discretion, any quantity and type of antipsychotic medication over the objections of a peaceful prisoner.

ARGUMENT

The Eighth Circuit adopted a standard for forced medication that expressly conflicts with the Sixth Circuit, and also runs afoul of the D.C. Circuit and Supreme Court. 282 F.3d 560. The court below held that by merely alleging fraud and submitting testimony from a government psychiatrist and psychologist, the federal government may subject a prisoner to unlimited mind-altering drugs over his objection. 282 F.3d at 571 (noting that the government psychiatrist "Dr. Wolfson did not name a specific medication," though he suggested likely possibilities). The court implicitly allowed drugs that have not been fully tested and approved for the specific purpose. Because the decision below is at odds with other Circuits and teachings of this Court, the petition for certiorari should be granted.

By fiat, the Eighth Circuit has granted the federal government an extraordinary means to punish without satisfying the burden of proof. Never before has an American court authorized a prison doctor to administer, in his sole discretion, any quantity and type of antipsychotic medication over the objections of a peaceful pretrial prisoner. 282 F.3d at 565 ("[W]e agree that the evidence does not support a finding that Sell posed a danger to himself or others at the Medical Center."). Government must not have the power to drug defendants simply by claiming it beneficial to do so, which Justice Brandeis expressly warned against: "experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent." *Olmstead v. United States*, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).

The seizure of this new federal power errs in fact as well as law. Petitioner Dr. Sell has already spent nearly five (5) years in prison (including nearly twenty months in solitary confinement) while the government has litigated this issue. This incarceration is more than a year *longer* than his severest sentence under the Sentencing Guidelines for the underlying fraud charges. The dissenting opinion below recognized the limit of 41 months on Dr. Sell's maximum sentence if convicted on the relevant charges, but the panel majority apparently failed to realize that he has already served far more than that period. 282 F.3d at 573 (Bye, J., dissenting). Government's interest in subjecting Dr. Sell to a trial can be no greater than its interest in sentencing him, which at this point is nil.

I. THE DECISION BELOW DIRECTLY CONFLICTS WITH OTHER CIRCUITS AND THIS COURT CONCERNING THE STANDARD OF REVIEW.

The dissent below described the conflict with other Circuits. The basis for requiring antipsychotic drugs for Dr. Sell here is quite similar to the facts found insufficient by the Sixth Circuit:

> The Sixth Circuit stated 'we find it difficult to imagine . . . that the government's interest in prosecuting the charge of sending a threatening letter through the mail could be considered a compelling justification to forcibly medicate Brandon." [*United States v. Brandon*, 158 F.3d 947, 961 (6th Cir. 1998)]; *cf. Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir. 1984) (questioning whether the state's interest in trying suspects could ever outweigh a criminal defendant's interest in avoiding forcible medication with antipsychotic drugs).

282 F.3d at 573 (Bye, J., dissenting).

The *Brandon* court expressly adopted a strict scrutiny standard that the panel majority below rejected. "We believe that the risk of error and possible harm involved in deciding whether to forcibly medicate an incompetent, non-dangerous pretrial detainee are . . . so substantial as to require the government to prove its case by clear and convincing evidence." *Brandon*, 158 F.3d at 961. The *Brandon* holding adhered to at least two Supreme Court lines of precedents, both implicitly rejected by the Eighth Circuit.

First, the "clear and convincing" standard is required by this Court in order to involuntarily commit a citizen:

> The individual should not be asked to share equally with society the risk of error when the possible injury to the individual is significantly greater than any possible harm to the state. We conclude that the individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence.

Addington v. Texas, 441 U.S. 418, 427 (1979). This high standard has frequently been affirmed by this Court in related contexts. *See, e.g., Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 282 (1989). In requiring this heightened level of scrutiny for state medical decisions, this Court foreclosed the relaxed standard applied by the Eighth Circuit here.

Second, this Court has applied the "clear and convincing" standard to state court determinations in family law, and it is inconsistent and unacceptable for federal courts to allow a lower standard. In *Santosky v. Kramer*, this Court reversed a decision of the New York family court because it separated children from their natural parents without satisfying the "clear and convincing" standard of proof. 455 U.S. 745, 747-48 (1980). "Before a State may sever completely and irrevocably the rights of parents in their natural child, due

process requires that the State support its allegations by at least clear and convincing evidence." *Id.* This Court held that "[f]ew forms of state action are both so severe and so irreversible"—the same reason the Sixth Circuit required heightened scrutiny of orders to alter citizens' minds. *Id.* at 759; *Brandon*, 158 F.3d at 961. *See also M. L. B. v. S. L. J.*, 519 U.S. 102, 118 (1996) (embracing the "clear and convincing" standard when a party's interest is "'commanding,'" and Dr. Sell plainly has a commanding interest here) (quoting *Santosky*, 455 U.S. at 758-59).

Federal Courts of Appeal have duly implemented the heightened standard for "commanding" personal interests akin to Petitioner Dr. Sell's with respect to his own mental state. In addition to the above-referenced Sixth Circuit decision in *Brandon*, the D.C. Circuit implicitly adopted the "clear and convincing" standard. "The district court held the government to a clear-and-convincing-evidence burden of proof. Neither party challenges this determination." *United States v. Weston*, 255 F.3d 873, 880 n.5 (D.C. Cir. 2001) (citing 134 F. Supp. 2d at 121 & n.12). The *Weston* court restated this in terms of what is "necessary" and "essential": "Accordingly, to medicate Weston, the government must prove that restoring his competence to stand trial is necessary to accomplish an essential state policy." 255 F.3d at 880. Defendant Weston, it is worth noting, was apprehended at the scene of the murder of two United States Capitol Police officers and the serious wounding of a third, and charged with those heinous crimes, in sharp contrast to the non-violent allegations here against Petitioner Dr. Sell.

Other Circuits have likewise imposed heightened burdens of proof as a prerequisite to mind-altering medication. In a widely followed ruling, the Tenth Circuit adhered to a standard of strict scrutiny in requiring that "less restrictive alternatives, such as segregation or the use of less controversial drugs like tranquilizers or sedatives, should be ruled out before resorting to antipsychotic drugs." *Bee v.*

Greaves, 744 F.2d 1387, 1396 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985). That Court ruled against prison officials because there was no evidence of an emergency to justify the forced treatment. "In view of the severe effects of antipsychotic drugs, forcible medication *cannot be viewed as a reasonable response to a safety or security threat if there exist 'less drastic means for achieving the same basic purpose.'*" *Id.* (emphasis added). The *Greaves* court even questioned whether a State's interest in trying a defendant could *ever* justify mandatory medication of him, a philosophical issue that this Court need not resolve here. *See id.* at 1395 ("[A]lthough the state undoubtedly has an interest in bringing to trial those accused of a crime, we question whether this interest could ever be deemed sufficiently compelling to outweigh a criminal defendant's interest in not being forcibly medicated with antipsychotic drugs."). *See also Kulas v. Valdez*, 159 F.3d 453, 455 (9th Cir. 1998) ("To force antipsychotic drugs on a prisoner or on a detainee awaiting trial **is impermissible** under the federal constitution, 'absent a finding of **overriding justification** and a determination of medical appropriateness.'") (quoting *Riggins v. Nevada*, 504 U.S. 127, 135 (1992)) (emphasis added).

The decision below contradicts these precedents. It flatly rejects *Brandon*, fails to mention *Greaves* or *Kulas*, and completely omits any reference to this Court's seminal *Addington* and related opinions. Instead, it focused on two precedents of this Court that do not entirely resolve the issue at hand, though they too point towards reversal of the Eighth Circuit here. *See Riggins v. Nevada*, *supra*; *Washington v. Harper*, 494 U.S. 210 (1990). The *Harper* decision emphasized that there is "no doubt that . . . [an inmate] possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment." *Id.* at 221-22. Its facts, however, entailed a post-conviction defendant, which

Dr. Sell is not. Hence that "significant liberty interest" recognized in *Harper* is far greater for Dr. Sell here.

Subsequently, the *Riggins* decision held that:

> 'The forcible injection of medication into a nonconsenting person's body . . . represents a substantial interference with that person's liberty.' In the case of antipsychotic drugs . . . that interference is particularly severe . . . .

Riggins, 504 U.S. at 134 (quoting *Harper*, 494 U.S. at 229). A court may override this liberty interest based only on "a finding that safety considerations or other **compelling** concerns outweighed [defendant's] interest in freedom from unwanted antipsychotic drugs." *Riggins*, 504 U.S. at 136 (emphasis added). As in *Harper*, the facts in *Riggins* did not require this Court to confront forced pretrial drugging. But Justices Thomas and Scalia observed that "[t]he standards for forcibly medicating inmates well may differ from those for persons awaiting trial." *Riggins*, 504 U.S. at 157 (Thomas and Scalia, JJ., dissenting). No one on this Court expressed disagreement.

The decision below erred in assuming that there is no difference in standard for forced medication of pretrial defendants compared to post-conviction defendants. The Eighth Circuit thereby allows the federal government to alter defendants' minds based merely on (1) unproven charges of non-violent crimes and (2) disputed testimony by government-hired witnesses. This contradicts the "compelling concerns" of this Court with respect to a peaceful defendant presumed by law to be innocent of the charges. *Riggins*, 504 U.S. at 136. Moreover, the decision below allows government to infringe on a defendant's right to decline government-mandated treatment in favor of treatment recommended by his own physician. *Sell*, 282 F.3d at 569-70.

The panel majority below did not once address the term "compelling" in its opinion. Instead, it relied heavily on a

district court opinion in California addressing similar facts. *Id.* at 568 ("[T]he Southern District of California refused to adopt a strict scrutiny standard."). But that court did insist on the heightened level of scrutiny of "clear and convincing evidence," in reliance on *Brandon*. *United States v. Sanchez-Hurtado*, 90 F. Supp. 2d 1049, 1055 (S.D. Cal. 1999) (quoting *Brandon*, 158 F.3d at 961).

In dictum, *Riggins* did allow that "'the state might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means.'" 282 F.3d at 566 (quoting *Riggins*, 504 U.S. at 135). But that comment was based only on the compelling need to punish defendant Riggins, who was condemned to death for "stabbing [another] 32 times with a knife . . . [and then taking] cash, drugs, and other items from [the victim's] home." 504 U.S. at 146 (Thomas, J., dissenting). That dictum is hardly controlling for Petitioner Dr. Sell, whom the Eighth Circuit ordered to be drugged based on a regulatory dispute over billings under the Medicaid program. Nor is Dr. Sell remotely comparable to the defendant in *Weston*, for whom "the government's interest . . . reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business." 255 F.3d at 881.

II. REVIEW IS NECESSARY TO ADDRESS THE PARAMOUNT ISSUE OF WHETHER THE FEDERAL GOVERNMENT HAS THE POWER TO FORCIBLY INJECT NON-VIOLENT, PRE-TRIAL DETAINEES WITH MIND-ALTERING DRUGS.

Federal police power cannot extend to drugging non-violent citizens, presumed to be innocent, on facts like Petitioner's. There is no basis for such authority in the enumerated federal powers, nor does it advance any legiti-

mate federal interest here. Its potential for abuse is unlimited, and the Petition presents an issue of paramount importance warranting review.

The core of the Bill of Rights—the Fourth through Eighth Amendments—protect citizens against an overzealous federal government. The Federalists, advocating passage of the Constitution without a bill of rights, declared them to be unnecessary because they guard against powers the federal government did not have. "For why declare that things shall not be done which there is no power to do?" The Federalist No. 84, p. 481 (Kesler and Rossiter ed. 1999). The Federalists surely would have scoffed at any suggestion that the federal government could require the injection of mind-altering drugs into peaceful, innocent citizens. Hence the Bill of Rights did not prohibit this inconceivable power. *Cf. Federal Maritime Comm'n v. S.C. State Ports Auth.*, 122 S. Ct. 1864, 1871 n.8 (2002) (noting the inappropriateness of a strict textual approach with respect to conduct "that itself lacks any textual basis in the Constitution").

A. Federal Enumerated Powers Do Not Include Forced Antipsychotic Medication.

Playing doctor falls outside federal jurisdiction. States regulate medical issues, like mental health, just as they have exclusive jurisdiction over family law and most education. *See, e.g.*, *United States v. Morrison*, 529 U.S. 598 (2000); *United States v. Lopez*, 514 U.S. 549 (1995). That does not prevent the federal government from detaining Dr. Sell until he is competent or has served the maximum punishment for his alleged crime. But the federal government cannot go beyond those remedies and force medical treatment on its presumed-innocent adversaries, any more than it can dictate family law decisions about them. Federal police power does not extend beyond its constitutional authority. *See*

Lopez, 529 U.S. at 564 (rejecting "a general police power," and citing the dissenting Justices' agreement with that principle).

The decision below further transgresses limited government by allowing the prison psychiatrist to inject any quantity or type of drugs into Dr. Sell, without oversight or accountability. In *Riggins*, this Court reversed the medication of the defendant, observing that "Riggins received a very high dose of the drug." 504 U.S. at 133; *see also id.* at 143 (Kennedy, J., concurring) (noting expert testimony that "'the dose he had been taking [] is very, very high [and] I mean you can tranquilize an elephant with'" such dose). The Court there held that defense counsel had not objected to the dose in a timely manner, implying that such an objection would have been proper. 504 U.S. at 133 (holding that "at no point did [defense counsel] suggest to the Nevada courts that administration of Mellaril was medically improper treatment for his client"). Yet the decision below deprives Dr. Sell of his right to object to the dosage or the type of drug to be administered, instead giving the prison psychiatrist *carte blanche* to inject him with whatever he chooses. 282 F.3d at 571 ("[W]e reject Sell's contention that he was not given the opportunity to make specific objections to specific drugs.").

This Court has emphatically rejected attempts by States, let alone the federal government, to engage in anything approaching mind control. *See West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943) (overruling *Minersville School Dist. v. Gobitis*, 310 U.S. 586 (1940)). The *Barnette* Court emphasized the "individual freedom of mind" as the strength of our country, "in preference to officially disciplined uniformity for which history indicates a disappointing and disastrous end." 319 U.S. at 637. Forced medication may promote uniformity, but the *Barnette* Court cautioned against "the uniformity of the graveyard." *Id.* at 641. Later, this Court extended that principle to protect

against compelled speech in *Wooley v. Maynard*, 430 U.S. 705 (1977). This doctrine carries even greater weight for injecting mind-altering drugs in defendants presumed to be innocent.

Allowing possibly untested treatments for Dr. Sell without his consent is particularly troubling. The failure of American courts to enforce the Nuremberg Code, which expressly prohibits the use of untested drugs without informed consent, has been tragic. The highest court of Maryland recently deplored this unfortunate chapter of American jurisprudence: "'[O]ur own use of prisoners, the institutionalized retarded, and the mentally ill to test malaria treatments during World War II was generally hailed as positive, making the war 'everyone's war.' Likewise, in the late 1940's and early 1950's, the testing of new polio vaccines on institutionalized mentally retarded children was considered appropriate. Utilitarianism was the ethic of the day.'" *Grimes v. Kennedy Krieger Inst., Inc.*, 366 Md. 29, 77, 782 A.2d 807, 836 (2001) (quoting Dr. George J. Annas, *Mengel's Birthmark: The Nuremberg Code in United States Courts*, 7 J. Contemp. Health L. & Pol'y 17, 24 (Spring 1991)). *See also In re Cincinnati Radiation Litig.*, 874 F. Supp. 796, 822 (S.D. Oh. 1995) (decrying that "the United States, aided by officials of the City of Cincinnati, treated at least eighty-seven (87) of its citizens as though they were laboratory animals").

The Supreme Court of Montana also recently rejected this utilitarian approach to forced medical treatment. *See In re Mental Health of K.G.F.*, 306 Mont. 1, 29 P.3d 485 (2001). It held that counsel would be presumed to be ineffective if he acquiesces in involuntary commitment for a mental disorder. That court rejected the utilitarian ethos:

> Nevertheless, our concept of due process regarding state action involuntarily imposed on individuals with mental disorders has surely progressed since the U.S. Supreme Court's decision in *Buck v. Bell*. In that case, Justice

> Holmes described a 'feeble-minded white woman,' who was the daughter of a 'feeble-minded mother' and the mother of an 'illegitimate feeble-minded child.' The Court declared that the woman, who was committed to the 'State Colony for Epileptics and Feeble Minded,' could be involuntarily sterilized in the 'best interest of the patients and of society' because: 'It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind . . . . Three generations of imbeciles are enough.'

306 Mont. at 13-14, 29 P.3d at 496 (quoting *Buck v. Bell*, 274 U.S. 200, 205-07 (1927)). *See also In re W.*, 637 P.2d 366, 368-69 (Colo. 1981) (agreeing with scholars who "have concluded that compulsory sterilization laws, no matter what their rationale, are unconstitutional in the absence of evidence that compulsory sterilization is the only remedy available to further a compelling governmental interest") (citing, *inter alia*, Burgdorf & Burgdorf, *The Wicked Witch Is Almost Dead: Buck v. Bell and the Sterilization of Handicapped Persons*, 50 Temp. L.Q. 995 (1977)).

Demonstrating the high potential for abuse of power, historians later discovered that neither the subject of the *Buck v. Bell* mandatory sterilization, Carrie Buck, nor her daughter, was mentally defective by today's standards. The daughter, in fact, was reportedly "very bright" and was listed on her school's honor roll. Albert W. Alschuler, *Law Without Values: The Life, Work, and Legacy of Justice Holmes* 65 (Univ. Chicago: 2000) (quoting Robert J. Cynkar, Buck v. Bell: *"Felt Necessities" v. Fundamental Values?*, 81 Colum. L. Rev. 1418, 1458 (1981)). There, as here, the factual claims were based on testimony by a government witness. And despite assurances of protections against abusive sterilizations, Carrie Buck's sister was even sterilized without her knowledge, under the ruse that she was having an appendectomy. Alschuler, *supra*, at 66 (citing Sheldon M. Novick, *Honorable Justice: The Life of Oliver Wendell Holmes* 478 n. 65 (Little, Brown: 1989)). Professor Alschuler observed that the *Buck v. Bell* decision imposing treatment without patient consent "merits its reputation for brutality." *Id.*

The same inhumane utilitarianism underlies the decision below. The testimony by Dr. Wolfson suggests eagerness to use novel drugs on Dr. Sell, without his consent:

> Q: Now, let me ask you this, what medications would you propose for Dr. Sell if you were to treat him?
> A: . . . There is another [drug] that they are hoping to have in a few months, that on paper looks very promising as well called Ziprazodone, Z-I-P-R-A-Z-O-D-O-N-E. As usual, there's experiment in Europe well before [its] introduction here. So that can be considered [too], if [it] shows up in time . . . .

Medication Hearing Transcript, September 29, 1999, at 90 (App. 7a).

The testimony that a new drug would be used on prisoner Sell "if [it] shows up in time" is disconcerting. *Id.* The court below required neither general FDA approval for the drugs to be used by Dr. Wolfson, nor authorization for their specific use. Drugs approved for one use by the FDA can be legally prescribed for unapproved and untested, "off-label" use. *See, e.g., "Off-Label" and Investigational Use of Marketed Drugs, Biologics, and Medical Devices*, FDA Guidance for Institutional Review Boards and Clinical Investigators (1998).[2] But such "off-label" use is based on patient consent, which is lacking here. The decision below authorizes the prison medical staff to drug Dr. Sell with "off-label", experimental uses, without the patient's consent.

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[2] Available online *at http://www.fda.gov/oc/ohrt/irbs/offlabel.html* (viewed 10/4/02).

B. Dr. Sell Has Already Served More Than a Year Longer than His Maximum Possible Punishment, and the Ordered Medication Does Not Advance Any Legitimate Governmental Interest.

Dr. Sell has already served nearly five (5) years in jail, twenty (20) months of which has been in solitary confinement, while the government has sought the power to medicate him. There is no legitimate governmental interest in punishing him further. His servitude has far exceeded his maximum sentence for the charges supposedly justifying his forced medication, and the incarceration continues. The dissent below noted that Dr. Sell's maximum imprisonment if convicted, under a very generous view of the government's relevant charges, is less than 3½ years. *Sell*, 282 F.3d at 573 (Bye, J., dissenting) ("his sentencing range would be 33-41 months"). The governmental interest in drugging Dr. Sell for trial can be no greater than its interest in punishing him further, which is non-existent.

In *Riggins*, the State's interest in medicating the defendant was to try him for the very purpose of inflicting additional punishment: the death penalty. 504 U.S. at 131. Nevertheless, this Court reversed an order requiring antipsychotic drugs, even though the State possessed this compelling interest in further punishing him. *See id.* at 134-38. Here, the federal government itself attempts to inject similar drugs into a defendant for whom it can impose no further punishment, and certainly not the death penalty. Its purported rationale for drugging Dr. Sell—to try him for a crime entailing no further imprisonment—is not a legitimate predicate.

The court below implied that Dr. Sell is somehow so despicable that he deserves this fate. It recounted an unfortunate incident in which Dr. Sell purportedly spat in the face of a magistrate, and implied that the incident occurred in court. 282 F.3d at 563. It did not. Nor was Dr. Sell ever

charged, much less convicted, for that allegation. As Dr. Sell explained on an investigatory wiretap, the incident was the result of his being struck on the head and repeatedly provoked while being led, handcuffed, to a holding cell. In a highly agitated state, and contrary to ordinary procedure, Dr. Sell was there confronted by an inexperienced magistrate, without the presence of his attorney as he was desperately requesting. It is highly prejudicial to Dr. Sell for the court below to cite this incident as evidence, as it did not occur in a courtroom and did not result in charges.[3]

Moreover, medication should never serve as a form of punishment, no matter how offensive the crime. "Forced administration of antipsychotic medication may not be used as a form of punishment. This conclusion follows inexorably from our holding in *Vitek v. Jones*, 445 U.S. 480 (1980), that the Constitution provides a convicted felon the protection of due process against an involuntary transfer from the prison population to a mental hospital for psychiatric treatment." *Harper*, 494 U.S. at 242 (Stevens, Brennan, Marshall, JJ., concurring and dissenting in part). Nor should the medical profession be misused as a tool for punishment.

The medical testimony in favor of injecting Dr. Sell here is woefully inadequate. It is based on only two witnesses, a government psychologist and psychiatrist, both of whom had limited experience and inadequate success rates. While the decision below stated that "the government must prove by clear and convincing evidence that the medication is medically appropriate," the evidence is anything but. 282 F.3d at 567. The federal government made no effort to obtain

---

[3] There were also accusations of intemperate remarks by Dr. Sell after being arrested by FBI agents. That incident, too, was recounted by the court below but does not justify the order for forced drugging. 282 F.3d at 563. There is no factual record about what incited the outburst, and it is not relevant to the Petition anyway.

the testimony of independent, qualified psychiatrists to justify its attempt to drug Dr. Sell. Dr. DeMier, the government psychologist who even lacked authority to prescribe medication, said he had experience with a grand total of only two patients similar to Dr. Sell—and the medication failed for one of them. *Id.* at 569. [4] Dr. Wolfson's experience was not much better, amounting to a total of only four patients, one of which was unsuccessful. *Id.*

The Eighth Circuit deferred to the district court under the clearly erroneous standard. But this evidence falls far short of the requisite "clear and convincing" standard. *Id.* at 567. It is convincingly clear that the injection of mind-altering drugs into Dr. Sell will alter his mind. Depending on dose and reaction, it may cause confusion, torpor, permanent disfiguring and disabling movement disorders, permanent brain damage and even death. Even the government expert conceded the substantial probability of "'significant side effects.'" *Id.* at 569 (quoting Dr. DeMier's testimony). But there is insufficient evidence, let alone "clear and convincing" evidence, that the drugging will render Dr. Sell competent for trial.

In the classic novel *1984*, George Orwell's hero is an Englishman named Winston Smith who faces a government attempt to extirpate his mental independence and spiritual dignity:

> O'Brien was standing at his side, looking down at him intently. At the other side of him stood a man in a white coat, holding a hypodermic syringe. . . . Did I not tell you just now that we are different from the persecutors

[4] The court below erred in finding the government provided testimony by two psychiatrists; in fact, one of those witnesses (Dr. DeMier) is a psychologist lacking authorization even to prescribe medicine. *Compare* 282 F.3d at 563 *with* Medication Hearing Transcript, September 29, 1999, at 20 (App. 4a).

> of the past? We are not content with negative obedience, nor even with the most abject submission. When finally you surrender to us, it must be of your own free will. We do not destroy the heretic because he resists us; so long as he resists us we never destroy him. We convert him, we capture his inner mind, we reshape him. We burn all evil and all illusion out of him; we bring him over to our side, not in appearance, but genuinely, heart and soul. We make him one of ourselves before we kill him. It is intolerable to us that an erroneous thought should exist anywhere in the world, however secret and powerless it may be.

George Orwell, *1984* at 243, 258 (Harcourt, Brace & World: 1949).

Dr. Sell likewise refuses to conform his mind to government preferences. Its response is an unrelenting effort to alter his mind through drugs. Not even imprisonment for nearly five years has satiated this desire to drug Dr. Sell. Its purported justification is to dispel Dr. Sell's allegedly delusional views of government. But this court-ordered drugging is self-defeating with respect to that stated purpose.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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October 7, 2002

APPENDIX

APPENDIX

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

Cause No. 4.97CR290 (DJS)
4:98CR177 (DJS)

UNITED STATES OF AMERICA,
Plaintiff,

vs.

CHARLES SELL,
Defendant,

TRANSCRIPT OF THE EVIDENTIARY HEARING

RE: INVOLUNTARILY PSYCHIATRIC TREATMENT AND MEDICATION BEFORE THE HONORABLE TERRY I. ADELMAN UNITED STATES MAGISTRATE JUDGE

TRANSCRIPT ORDERED BY: Lee T. Lawless

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Recorded By: Karen Moore,
Court Reporter

Transcribed By: Carter Transcription &
Reporting Company

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[4] MR. LAWLESS: Yes, that they,—I'd probably would like a copy of their,—

MR. MARCUS: Mr. Short has a copy,—

MR. LAWLESS: Get me one too, to put into the record.

MR MARCUS: Okay.

MR. LAWLESS: But, we are not going to contest it,—testify his expert witnesses.

MR. MARCUS: Your Honor, at this time I would call Dr. Richart DeMier.

MR. LAWLESS: I'd like to invoke the rule to exclude witnesses.

THE COURT: Okay.

RICHART DEMIER, GOVERNMENT'S SWORN

MR. MARCUS: May I proceed?

THE COURT: You may proceed.

DIRECT EXAMINATION

BY MR MARCUS:

Q All right, Mr. DeMier I'm going to hand you what has been marked Government's Exhibit 2 which is a,—we would ask you to identify this for us please?

A Yes. That's my Curriculum Vitae, which describes my education and clinical experience.

MR. MARCUS: I would like to offer Government's Exhibit 2 in evidence at this time.

[5] THE COURT: Any objection?

MR. SHORT: No.

THE COURT: May be so admitted. Thank you.

BY MR. MARCUS:

Q All right, Dr. DeMier, what is your occupation?

A I'm a Clinical Psychologist.

Q And, by whom are you employed?

A I'm employed by the U.S. Medical Center for Federal Prisoner's

Q And how long have you been there?

A I've worked at that institution four or five years.

Q Okay. Dr. DeMier in your capacity, at the Medical Center in Springfield, have you had an opportunity to have contact with Dr. Sell?

A Yes, I have.

Q And what would be your role as to Dr. Sell in the institution?

A I evaluated Dr. Sell when he was admitted for an evaluation of competency, that evaluation occurred between February 24th and March 25th of this year. I have also worked with him since his return to our institution on April 20th of this year, when he was committed for competency restoration treatment.

Q And when he was committed initially and now you have been his attending clinical?

* * * *

[20] in the treatment and care of two patients diagnosed with delusional disorder frequency.

Q In delusional disorder, is somewhat of a rare diagnoses?

A Yes, it is fairly infrequent.

Q And it would have been a new diagnosis since 1987?

A That's correct.

Q And, in the two that you have seen,—now as a psychologist, you cannot prescribe medicine, but you were involved in the treatment and you saw how the medicine was prescribed and worked?

A That's correct.

Q What was the treatment that was used in these two gentlemen?

A In both cases the patients were prescribed anti-psychotic medications.

Q And do you recall which medications in these two cases?

A One patient was prescribed Haldol, the other was prescribed Olanzapine.

Q And these are both anti-psychotics?

A Yes, they are.

Q And in the two cases were you able to restore to competency either of the two?

A Yes.

* * * *

[73] obviously I'm,—

MR. LAWLESS: I didn't feel that way like that.

THE COURT:—you had something to do, you do it, okay.

MR. LAWLESS: Thank you.

THE COURT: Mr. Marcus.

MR. MARCUS: I have no redirect.

THE COURT: Dr. DeMier, thank you very much. You may be excused.

WITNESS: You're welcome, your Honor.

THE COURT: You may call your next witness. I'll take that back, why don't we take about three,—five minute recess.

(Temporary Recess From. 10:50 p.m. Until 11:05 p.m.)

THE COURT: Mr. Marcus, you may proceed.

MR. MARCUS: Your Honor, at this time the Government would call Dr. James K. Wolfson.

JAMES K. WOLFSON,
GOVERNMENT'S WITNESS, SWORN

DIRECT EXAMINATION

BY MR. MARCUS:

Q Sir, for the record can you state your name please?

A Yes. James K. Wolfson, M.D.

Q And Mr. Wolfson, where do you currently work?

A I'm at the U.S. Medical Center for Federal [74] Prisoners in Springfield, Missouri.

Q And what is your current position there?

A I'm a staff psychiatrist, I'm the only psychiatrist who is on the forensic service along with other psychologists colleges.

Q All right. Dr. Wolfson, I'm going to hand what has been marked Government's Exhibit 3, and ask you to identify this for us please?

A This is my Curriculum Vitae.

MR. MARCUS: Your Honor, at this time I'd offer Government's Exhibit 3 into evidence.

MR. SHORT: I have no objection.

THE COURT: It be so admitted. Thank you Mr. Marcus.

Q All right. Dr. Wolfson, as staff psychologist at the Medical Center in Springfield, had you been involved in the treatment of Dr. Sell?

A Yes, I have.

Q And, would it be fair to characterize your role in his treatment as a consultant?

A Yes, it would be.

Q And, one of the issues you are involved in consulting, would be the potential use of medication for him?

A Yes. That is how I'm connected to everyone of the

* * * *

[90] Q Now, let me ask you this, what medications would you propose for Dr. Sell if you were to treat him?

A I prefer not to get pinned down to a single drug, because part of this I hope to actually leave in his hands, to pick among available alternatives, so he can at least have some role in the decision making process. Of the atypical agents, there are two; Quetiapine, should I spell that for the transcription,—Q-U-E-T-I-A-P-I-N-E,—

MR. SHORT: I'm sorry, can you spell that again please?

THE WITNESS: Quetiapine. Q-U-E-T-I-A-P-I-N-E, sold as the brand name Seroquel, S-E-R-O-Q-U-E-L. And, another medication, Olanzapine, O-L-A-N-Z-A-P-I-N-E, which is sold as Zyprexa, Z-Y-P-R-E-X-A, and those are the,—I think the two of the three, for atypical agents, those are the two that make the most sense. There is another one that they are hoping to have in a few months, that on paper looks very promising as well called Ziprazodone, Z-I-P-R-A-Z-O-D-O-N-E. As usual, there's experiment in Europe well before it's introduction here. So that can be considered to, if shows up in time, but those are the ones that make the most sense, be most likely to have a benign side effect so profile.

* * * *

Supreme Court, U.S.
FILED
OCT -7 2002
OFFICE OF THE CLERK

No. 02-5664

In The

Supreme Court of the United States

DR. CHARLES THOMAS SELL, D.D.S.,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF AMICUS CURIAE AMERICAN CIVIL LIBERTIES UNION OF EASTERN MISSOURI IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the government can violate a pretrial detainee's fundamental right to bodily integrity by injecting him with permanently mind-altering psychotropic drugs against his will solely to medicate the individual into drug-induced competence for trial?

2. Whether the court below applied the wrong standard of scrutiny and the government failed to establish a compelling interest sufficient to violate petitioner's fundamental right to bodily integrity?

3. Whether the court below failed to give proper weight to petitioner's liberty interests that require a strict scrutiny review?

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INTEREST OF AMICUS CURIAE[1]

The American Civil Liberties Union of Eastern Missouri is an affiliate of the American Civil Liberties Union ("ACLU"), a nonpartisan, nonprofit organization founded in 1920, whose purpose is to defend the Bill of Rights. The ACLU of Eastern Missouri has its principal place of business in St. Louis, Missouri and has 2,500 members. As part of its mission, the ACLU of Eastern Missouri has participated, either as counsel or as *amicus*, in numerous cases supporting individuals' First, Fifth, Sixth and Fourteenth Amendment interests, including the rights of individuals to refuse involuntary medication by the government.

SUMMARY OF THE ARGUMENT

I. The court of appeals' holding that an intermediate level of scrutiny is sufficient to allow the government to forcibly administer psychotropic medication for the sole purpose of rendering the Petitioner, a nondangerous pretrial detainee, competent to stand trial is in direct conflict with the decision of another Court of Appeals that strict scrutiny is required to satisfy a nondangerous pretrial detainee's due process rights. The Court should grant certiorari to resolve this conflict among the Circuits.

[1] Pursuant to Rule 37.2(a), letters of consent from both parties have been filed with the Clerk. Pursuant to Rule 37.6, counsel represent that this brief was not authored in whole or in part by counsel for any party and that no person or entity other than *amicus*, their members, or counsel made a monetary contribution to preparing or submitting this brief.

II. It is well established that there is a constitutionally protected liberty interest in the right to bodily integrity. This Court, however, has never addressed whether the right to bodily integrity includes the right of a nonviolent, nondangerous, pretrial detainee to refuse psychotropic medication administered for the sole purpose of regaining competency for trial. Because the Petitioner has a constitutionally protected liberty interest in the right to bodily integrity, and because his right to bodily integrity is a fundamental right, the Petition should be granted to answer this question of first impression.

III. The court of appeals applied an intermediate scrutiny test without first determining whether or not the challenged state action implicated a fundamental right of the Petitioner. A proper analysis requires the Court first to determine if a fundamental right of the Petitioner is implicated. If a fundamental right is implicated, as it is in this case, then the Court must determine whether the state has a compelling interest to abrogate the Petitioner's fundamental right. The lower court failed to engage in a proper analysis of the Petitioner's rights, and that the government has not met its burden of proving a compelling state interest for violating Petitioner's liberty interest to be free from involuntary medication.

REASONS FOR GRANTING THE WRIT

The Petition should be granted to resolve the divergent opinions in the lower federal and state courts regarding the standard of scrutiny and burden of proof to be applied to the government's efforts to forcibly medicate an individual solely for the purpose of making the individual

competent to stand trial. The same standard should be applied to all individuals regardless of the federal circuit with jurisdiction.

Petitioner, Dr. Charles Sell has not been convicted of a crime. Though accused of nonviolent crimes and found to pose no risk to himself or others, he has been imprisoned for more than four years without a trial. The government seeks to medicate Dr. Sell by injecting him with permanently mind-altering psychotropic drugs against his will to induce a drug-dependent competence so that the government can bring him to trial on charges involving alleged economic crimes of fraud and money laundering. If the Eighth Circuit Court of Appeals' decision is allowed to stand, a mentally incompetent individual in that Circuit will lose his First, Fifth, and Sixth Amendment rights to refuse medication based solely on the government's unproven assertion that he is guilty of nonviolent crimes.

The petition should also be granted to determine whether an individual has a fundamental right to refuse the government's attempts to forcibly medicate him and violate his Constitutional rights for a purely prosecutorial motive.

I. The Petition Should Be Granted To Resolve Conflicts Among The Courts Of Appeals Regarding The Government's Power To Forcibly Medicate A Pretrial Detainee Accused Of Nonviolent Crime To Make Him Competent For Trial.

The Eighth Circuit decision in this case directly conflicts with a Sixth Circuit decision regarding the same issue. The decision also misapplies relevant decisions

decided by this Court. The Supreme Court may grant a petition for certiorari if "a United States court of appeals has entered a decision in conflict with another United States court of appeals on the same important matter . . . or a United States court of appeals has decided an important federal question in a way that conflicts with relevant decisions of this Court." Sup. Ct. R. 10(a), (c). Both circumstances occurred in this case.

A. The Sixth and Eighth Circuits Directly Conflict on the Appropriate Level of Scrutiny Applied to the Forced Medication Solely for Competence of Nonviolent Pretrial Detainees

The Eighth Circuit in this case applied intermediate scrutiny in determining whether a pretrial detainee may be forcibly medicated with psychotropic drugs solely to render him competent for trial. *U.S. v. Sell*, 282 F.3d 560, 566 (8th Cir. 2002). Sell, who has been detained for four years, is charged with sixty-three counts of fraud and money laundering. After the district court found him incompetent to stand trial, the Eighth Circuit held that although Sell posed no danger to himself or others, "the [g]overnment's interest in restoring Sell to competency so that he can stand trial was alone sufficient to warrant forcible medication" *Id.* In so ruling, the court applied intermediate scrutiny and set forth a three-part test for the forced medication of an individual. *Id.* at 567. The test requires that the "government must present an essential state interest that outweighs the individual's interest in remaining free from medication"; "the government must prove there is no less intrusive way of fulfilling its essential interest"; and "the government must prove by clear

and convincing evidence that the medication is medically appropriate." *Id.* The court also held that any Sixth Amendment rights against the forced medication could be considered *after* the medication began.

This decision is in direct conflict with the Sixth Circuit's determination that to forcibly medicate a pretrial detainee, "the government must satisfy strict scrutiny review and demonstrate that its proposed approach is narrowly tailored to a compelling interest." *U.S. v. Brandon*, 158 F.3d 947, 957 (6th Cir. 1998). The court emphasized that this government interest "relates solely to trial administration rather than to prison administration." *Id.* at 957. In *Brandon*, the detainee was charged with sending a threatening communication through the mail. *Id.* at 950-51. Like Sell, Brandon was found incompetent to stand trial. The Sixth Circuit instructed that Brandon was entitled to a hearing in which strict scrutiny is applied. *Id.* at 960. The court noted that the medication affected the "nondangerous pretrial detainee's fundamental right to be free from bodily intrusion," his "First Amendment interest in avoiding forced medication, which may interfere with his ability to communicate ideas," and his "Sixth Amendment right to a fair trial." *Id.* at 953-54. Though it remanded the case for a hearing, the court "f[ou]nd it difficult to imagine . . . that the government's interest in prosecuting the charge of sending a threatening letter through the mail could be considered a compelling justification to forcibly medicate Brandon." *Id.* at 961.

The decision of the court below not to apply strict scrutiny relied, in part, on *U.S. v. Weston*, 255 F.3d 873, 880 (D.C. Cir. 2001). But, unlike the decision of the court below, *Weston* did weigh the governmental interest at length, finding that the grave nature of Weston's alleged

crimes (murder) rendered the government's interest "essential." *Weston*, 225 F.3d at 881. The *Weston* court acknowledged that, in spite of cases describing the government's general interest in adjudicating crimes as "essential" and even "compelling," the government's interest is not absolute: "We need not decide under what circumstances trying and punishing offenders is not 'essential.' The government's interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business." *Id.* at 880. Thus, *Weston* deals with the narrow issue of the government's interest in adjudicating violent crimes that carry substantial punishments and should not be held to stand for the principle that the governmental interest in bringing *all* individuals to trial is generally compelling even when the charges against the individual involve less serious nonviolent offenses.

While the court below seemed to acknowledge a duty to analyze the nature of the government's interest, it failed to satisfy this requirement. The majority opinion stated, "[n]ot all charges . . . are sufficient to justify forcible medication of a defendant; rather the charges must be serious." *Sell*, 282 F.3d at 568, *citing Brandon*, 158 F.3d at 961. The court's analysis of the charges against Dr. Sell consisted of a single sentence conclusively stating that the charges are serious. *Sell*, 282 F.3d at 568. The court below failed to explain *why* or *how* the charges are serious, which is essential to analyzing whether the government's interest in prosecuting these charges would be considered essential and compelling. Noting the majority's lack of analysis and explanation for its claim of severity, Justice Bye stated in his dissent, "[a]t first blush, the sixty-two

counts of fraud and the single count of money laundering might appear to make the charges seem more serious, but the sheer number is an inaccurate yardstick for measuring the severity of [Petitioner's] alleged offenses." *Id.* at 573 (J. Bye, dissenting). The lack of severity of the charges coupled with the severity of the intrusion on Petitioner's rights does not lend itself to the conclusion that the government's interest in bringing Petitioner to trial is compelling.

By failing to establish and analyze how Petitioner's rights were affected or how the governmental interest weighs against Petitioner's interest, the majority's interpretation resulted in a test that departs from established analysis for governmental infringements of fundamental liberties. *See Washington v. Harper*, 494 U.S. 210, 223-224 (1990). This flaw influenced how the court analyzed both the individual liberty interests and the competing government interests in the balance, resulting in an ultimately flawed test. The Writ should be granted to establish the proper standard of review.

B. The Panel Misapplied *Washington v. Harper* and *Riggins v. Nevada* Which Apply To Dangerous Or Imprisoned People.

This Court has recognized that forced medication implicates a defendant's Fifth Amendment liberty interest in being free from bodily intrusion: "The forcible injection of medication into a non-consenting person's body represents a substantial interference with that person's liberty." *Harper*, 494 U.S. at 229. Dr. Sell's liberty interest is heightened by the fact that the medications at issue have serious and sometimes irreversible side effects. *See Id.* ("While the therapeutic benefits of antipsychotic drugs are

well documented, it is also true that the drugs can have serious, even fatal, side effects."); *Brandon,* 158 F.3d at 954 ("Although the various drugs might have beneficial results, the concomitant side effects might be severe and irreversible"). The court below applied the test used in *Harper,* as set forth in *Riggins v. Nevada*, 504 U.S. 494 (1977), and failed to consider that prisoners have diminished liberty interests compared to nondangerous pretrial detainees charged with nonviolent offenses. *See Sell*, 282 F.3d at 567.

Riggins noted that pretrial detainees have *at least* the same rights as prisoners, though it identified situations in which the government may be able to show an "overriding justification" sufficient to warrant involuntary medication to a trial or pretrial setting. *Riggins*, 504 U.S. at 135 (emphasis added). The *Riggins* test doesn't address the higher liberty interest enjoyed by non-prisoners. The Sixth Circuit has acknowledged this distinction, noting that the individual's liberty interest in the non-prison setting, particularly where not dangerous, rises to fundamental status in which strict scrutiny is required. *Brandon*, 158 F.3d at 957.

Riggins expressly considered the danger level of the prisoner in its balancing test. "Taking account of the unique circumstances of penal confinement, however, we determined that due process allows a mentally ill inmate to be treated involuntarily with antipsychotic drugs *where there is a determination that 'the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.'*" *Id.* at 135, *quoting Harper* at 227 (emphasis added).

Harper, *Riggins*, and *Weston* involved defendants found to be dangerous to themselves or others. The court below failed to consider that Dr. Sell was not dangerous nor a convicted prisoner, and it therefore unduly expanded the *Harper* and *Riggins* holdings to include nondangerous pretrial detainees charged with nonviolent offenses.

II. The Petition Should Be Granted To Determine An Issue Of First Impression: Whether The Government Can Violate A Pretrial Detainee's Fundamental Right To Bodily Integrity By Involuntarily Medicating Him With Permanently Mind-Altering Psychotropic Drugs Solely To Medicate The Individual Into Drug-Induced Competence For Trial.

It is well established that there is a constitutionally protected liberty interest in the right to bodily integrity. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). This Court has never addressed whether this right includes the right of a nonviolent, nondangerous, pretrial detainee to refuse psychotropic medication administered for the sole purpose of regaining competency for trial. *Cruzan* found that the right to bodily integrity is embodied in the general requirement of informed consent for medical treatment. *Cruzan*, 497 U.S. at 269. That Court embraced the idea that "[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is to refuse treatment." *Id.* The Court found that "a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278. The right to refuse medical treatment is grounded in the notion of liberty that is "inextricably entwined with our idea of

physical freedom and self-determination." *Id.* at 287 (J. O'Connor, concurring). No case law exists on specific issue of a nonviolent pretrial detainee's fundamental right to bodily integrity in the refusal of psychotropic drugs to gain competence to stand trial. The Petition should be granted to answer this question of first impression.

When defining what constitutes a fundamental right, courts look to "[o]ur Nation's history, legal traditions, and practices" to find those rights and liberties which are "deeply rooted in this Nation's history and tradition." *Cruzan*, 497 U.S. 305 (J. Brennan, dissenting) (*quoting Bowers v. Hardwick*, 478 U.S. 186, 192 (1986) (*quoting Moore v. East Cleveland*, 431 U.S. 494, 503 (1977))). Moreover, a fundamental right is "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937).

The Supreme Court has long accepted the existence of a liberty interest in the right to bodily integrity. In *Union Pacific Railroad Co. v. Botsford*, 141 U.S. 250 (1891), the Court recognized that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Id.* at 251. Justice Brennan, in his *Cruzan* dissent, applied the above stated considerations for determining if a liberty interest is fundamental and found, "[t]he right to be free from medical attention without consent, to determine what shall be done with one's own body, *is* deeply rooted in this Nation's traditions, as the majority acknowledges."

Cruzan, 497 U.S. at 305 (J. Brennan, dissenting) (emphasis in original). Justice Brennan correctly concluded that if "a competent person has a liberty interest to be free of unwanted medical treatment, as both the majority and Justice O'Connor concede, it must be fundamental." *Id.* Given that this Court has recognized a liberty interest to bodily integrity since at least 1891, it clearly is "deeply rooted in this Nation's history and traditions" and should be expressly confirmed as a fundamental right as to nondangerous pretrial detainees. The Petition should be granted to answer this important question of first impression.

III. The Court Below Failed To Consider All Of Petitioner's Liberty Interests That Require Strict Scrutiny Review And Failed To Find A Compelling Government Interest Necessary To Implicate Petitioner's Fundamental Right To Bodily Integrity.

While the court below acknowledged that involuntary medication invoked "significant liberty interests," it did not apply strict scrutiny but instead applied an intermediate "heightened scrutiny" test. *Sell*, 282 F.3d at 568. The first part of the three-part test articulated below consisted of balancing individual rights against the competing governmental interests. *Id.* at 567. However, the determination how the Petitioner's rights are affected must occur *before* determining the standard of review, as the nature of the individual's rights at stake determines the appropriate standard of review. Once the nature of the individual's affected rights are established and the appropriate standard of review has been determined, the court can then compare the government's interests to the individual's

rights to ensure a balance can be struck. *Brandon*, 158 F.3d at 959. ("In substantive due process analysis, a balance of rights is struck by deciding the appropriate standard of review in the first place.") (*citing Harper*, 494 U.S. at 223-24). The Eighth Circuit in this case failed to conduct this analysis.

A proper analysis of this case begins with the threshold question of whether the challenged state action implicates a fundamental right. *Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997). This requires a "careful description" of the petitioner's asserted fundamental liberty interest. *Id.* at 721. This inquiry is a necessary prerequisite to determining the applicable standard of review. However, the court of appeals' passing reference to Dr. Sell's "significant liberty interest," *Sell*, 282 F.3d at 568, fails to adequately assess or describe the fundamental interest at stake. Indeed, there is no discussion of the character or legal tradition of the right to refuse medication. Without making this threshold inquiry, it was improper for the court below to proceed to balance the Petitioner's interests against the state's interest.

If a fundamental right is implicated, a court must then assess whether the state has advanced a "compelling interest." *Glucksberg*, 521 U.S. at 721. Where fundamental rights are invoked, the remainder of the balancing test cannot take place if the government's interest is not compelling. *Brandon*, 158 F.3d at 959. In *Brandon*, the Sixth Circuit found that the government's interest in prosecuting did not outweigh the defendant's fundamental right to refuse medications. *Id.* The *Brandon* Court doubted "that the government's interest in prosecuting the charge of sending a threatening letter through the mail could be considered a *compelling* justification to forcibly

medicate [Defendant]." *Id.* In the case at hand, the court below failed to analyze whether the government's interest in bringing Dr. Sell to trial was compelling enough to override his fundamental liberty interest. Rather, it simply labeled the governmental interest in prosecuting defendants as "essential." *Sell*, 282 F.3d at 568 (*citing Illinois v. Allen*, 397 U.S. 337 (1970)). The dissent aptly noted the majority's lack of analysis and engaged in the requisite discussion, persuasively demonstrating that the government had not met its burden of proving a compelling interest. *Id.* at 571-73 (J. Bye, dissenting). Justice Bye's dissent makes clear that based on the lack of severity of the charges against Dr. Sell and the liberty interest at stake, the government's interest in prosecuting Dr. Sell's alleged economic crimes is not compelling.

A. The Court Below Failed To Acknowledge A Defendant's First Amendment Interest To Be Free From Involuntary Medication.

The court below failed to acknowledge the First Amendment interests of nonviolent pretrial detainees to be free from involuntary medication. The Sixth and Tenth Circuits have found that the forced medication of a pretrial detainee affects his ability to produce ideas in violation of his freedom of speech under the First Amendment. *Brandon*, 158 F.3d at 953; *Bee v. Greaves*, 744 F.2d 1387, 1393-94 (10th Cir. 1984). A defendant facing involuntary medication enjoys "a First Amendment interest in avoiding forced medication, which may interfere with his ability to communicate ideas," *Brandon*, 158 F.3d at 953, *citing Greaves*, 744 F.2d at 1393-94 ("Antipsychotic drugs have the capacity to severely and even permanently affect an individual's ability to think and communicate.") The

interest in retaining one's identity and communicative process is substantial enough to invoke strict scrutiny. The court below entirely failed to consider this interest when determining the nature of the scrutiny to be applied. Moreover, even under the lower standard articulated by the majority, the court below failed to weigh Petitioner's due process rights in its balancing test. Accordingly, the granting of this Petition is warranted.

B. The Decision of the Court Below Failed To Consider Fully The Impact Of Forced Medication On A Defendant's Right To A Fair Trial.

Forced medication by the government also implicates a defendant's right to a fair trial as protected by the Due Process Clause and the Sixth Amendment. In his concurring opinion in *Riggins*, Justice Kennedy warned that the mind-altering effect of antipsychotic drugs might infringe upon a defendant's right to effective assistance of counsel by making him unable to assist in his own defense. *Riggins*, 504 U.S. at 139-41 (J. Kennedy, concurring).

The opinion of the court below improperly failed to include an analysis of a defendant's right to a fair trial. Though the court below determined that a Sixth Amendment inquiry is not ripe prior to the administration of the medication, its Fourteenth Amendment fair trial analysis acknowledges "that before forcibly medicating an accused, there must be evidence that he will be able to participate in a fair trial." *Sell*, 282 F.3d at 571. In spite of this reference, the majority's opinion fails to instruct how this analysis applies to its test and what burden of proof must be met.

The government's burden is higher when seeking to medicate pretrial detainees because it must show that its interest not only outweighs the defendant's right to be free from unwanted bodily intrusion but also that it outweighs the possibility that his right to a fair trial may be implicated. Thus, in balancing a state's interest in medicating a nondangerous defendant for the sole purpose of rendering him competent to stand trial, the court must consider not only his right to be free from forced medication, or his right to express his identity, but also his right to receive a fair trial and pursue a defense. The court below did not engage in this necessary analysis.

Under the test articulated by the court below, a balance was struck only between the state's interest in bringing a defendant to trial with Dr. Sell's interest in refusing unwanted medication. The lower court failed to consider Dr. Sell's right to a fair trial at all. Thus, even under the intermediate scrutiny test proposed by the court below, the first prong – that the government's interest outweighs the defendant's liberty interest – is in need of reconsideration to include the defendant's interest in having a fair trial in the balancing test.

Certainly a nondangerous individual's rights to express his identity and to be free from forced medication alone are sufficient to invoke a liberty interest requiring strict scrutiny review. It follows that when such an individual is being detained for trial, his rights to due process and a fair trial invoke additional liberty interests warranting strict scrutiny review. Arguably, even when involuntary medication may be justified where a defendant is dangerous, the state's interests in bringing the defendant to trial cannot override a detainee's right to a fair trial.

Clearly, the state's interests are even less when the defendant has been deemed not dangerous.

The lower court's reliance on *Riggins* is misplaced. *Riggins* involved a pretrial detainee who had agreed to medication, eventually attained competence, and then during trial tried to assert a right to discontinue the medication, which at least one other court has found distinguishable from a pretrial detainee who has not already agreed to be medicated. *U.S. v. Sanchez-Hurtado*, 90 F.Supp.2d 1049, 1053 (S.D. Cal. 1999).

Because the court below failed to properly balance the defendant's right to a fair trial, not just against the government interest, but also in determining the extent of the government interest in the first place, this Petition should be granted.

CONCLUSION

The writ of certiorari should be granted.

Respectfully submitted,

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No. 02-5664

IN THE

Supreme Court of the United States

DR. CHARLES THOMAS SELL, D.D.S.,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF AND *AMICUS CURIAE* BRIEF OF THE LAW OFFICE OF JULIE RUIZ-SIERRA IN SUPPORT OF THE PETITION FOR CERTIORARI

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MOTION FOR LEAVE TO FILE *AMICUS CURIAE*
BRIEF IN SUPPORT OF PETITION
FOR CERTIORARI

COMES NOW the Law Office of Julie Ruiz-Sierra and respectfully moves this Court for leave to file an *amicus curiae* brief in support of the petition for certiorari, pursuant to Rule 37(2)(b) of the Rules of Court, and in support of this motion, states:

1. The law firm of Lewis, Rice, and Fingersh, L.C., as counsel for the petitioner, Dr. Charles Thomas Sell, D.D.S., has withheld consent to Julie Ruiz-Sierra's request to file an *amicus curiae* brief in support of the petition for certiorari.

2. The Law Office of Julie Ruiz-Sierra (LOJRS) is a solo criminal defense practice in Davis, California, specializing in drug offenses and dedicated to drug policy reform advocacy. Julie Ruiz-Sierra lectures on the impact of drug prohibition on civil rights and teaches workshops on invoking fundamental rights during a police encounter as a public service. She has been an activist for drug policy reform and a research specialist in drug law since 1997.

3. As part of its philosophical commitment to ending drug prohibition, LOJRS supports the advancement of drug policies that construe drug abuse as a social and medical issue rather than a criminal justice issue. LOJRS promotes the policy stance that individuals should not be punished for what they put into their own bodies so long as they do not cause proximate harm to others and promotes the concept of the individual's sovereignty over his own mind and body.

4. As a legal practice devoted to promoting the physical and mental autonomy of the individual, LOJRS recognizes the fundamental right of bodily integrity. This universally recognized human right, which assures the inviolability of the human body

and an individual's autonomous decision-making authority in matters affecting his or her body and mind, is one of the most basic aspects of the expression of free will necessary for the enjoyment of liberty.

5. LOJRS has a critical interest in this case because the government's claim of authority to involuntarily administer psychotropic medication to non-dangerous pretrial detainees for the sole purpose of rendering them competent to stand trial constitutes a serious infringement of the fundamental right to bodily integrity. Said claim, if the decision of the court below is affirmed, would be a threat to the development of progressive governmental drug policy and would set dangerous judicial precedent for the use of involuntary medication in other criminal justice contexts. As a practice with over five years of experience in drug policy issues, The Law office of Julie Ruiz-Sierra has developed expertise that can aid this Court in understanding the broad implications this case holds for the liberty interest of all Americans to exercise control over their own bodies and refuse unwanted medication. Accordingly, the undersigned counsel's perspective on this issue would be of interest to this Court.

WHEREFORE, for the forgoing reasons, the Law Office of Julie Ruiz-Sierra respectfully requests this Court grant its motion for leave to file its brief as *amicus curiae* in support of the petition for certiorari.

Respectfully submitted,

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INTEREST OF *AMICUS CURIAE*

Without the written consent of the parties, and on a motion to this Court for leave to file, the undersigned counsel submits this brief as *amicus curiae* in support of petitioner pursuant to Rule 37(2)(b) of the Rules of Court.[1]

The Law Office of Julie Ruiz-Sierra (LOJRS) is a solo criminal defense practice in Davis, California, specializing in drug offenses and dedicated to drug policy reform advocacy. Julie Ruiz-Sierra lectures on the impact of drug prohibition on civil rights and teaches workshops on invoking fundamental rights during a police encounter as a public service. She has been an activist for drug policy reform and a research specialist in drug law since 1997.

As a legal practice devoted to promoting the physical and mental autonomy of the individual, LOJRS recognizes the fundamental right of bodily integrity. This universally recognized human right[2], which assures the inviolability of the human body and an individual's autonomous decision-making in matters affecting his or her body and mind, is one of the most basic aspects of the expression of free will necessary for the enjoyment of liberty. Indeed, the right of bodily integrity is acknowledged to be one of the most cherished freedoms in a civil society[3].

---

1. No counsel for a party authored this brief in whole or part, and no person or entity other than the Law Office of Julie Ruiz-Sierra, as *amicus curiae*, or its counsel, made a monetary contribution to the preparation and submission of this brief.

2. *The Universal Declaration of Human Rights*, art. 3, G.A. Res. 217A (III), at 71, U.N. Doc. A/810 (1948). ("Article 3: Everyone has the right to life, liberty, and security of person.")

3. Denis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 La. L. Rev. 283, 284 (1992).

Perhaps no image so horrifically evokes the specter of oppressive government as that of a hypodermic syringe in the hands of a government agent, aimed at the defenseless body of an unwilling citizen. LOJRS has a critical interest in this case because the government's claim of authority to involuntarily medicate Dr. Sell, a non-dangerous pretrial detainee afforded the presumption of innocence, has broad implications for the liberty interest of all Americans to exercise control over their own bodies and refuse unwanted medication. LOJRS submits that the administration of unwanted psychotropic medication to incompetent defendants for the sole purpose of rendering them competent to stand trial constitutes a serious infringement of the fundamental right to bodily integrity which deserves the highest level of scrutiny afforded under the Due Process Clause of the Fifth and Fourteenth Amendments to the United States Constitution.

SUMMARY OF ARGUMENT

The proscription against trying the incompetent has long been an elemental tenet of constitutional criminal procedure. *See Bishop v. United States*, 350 U.S. 961 (1956) and *Pate v. Robinson*, 383 U.S. 375 (1966). It is one of the features that ensure the constitutional guarantee to a fair trial by providing that trials lacking a fundamental level of fairness should not be held at all. Today, courts around the nation are variously interpreting that guarantee as a justification for involuntarily medicating incompetent pre-trial detainees in order to "render them competent to stand trial." The court below has affirmed an order to involuntarily medicate Dr. Sell, a non-violent pre-trial detainee, with psychotropic medication for this purpose. *United States v. Sell*, 252 F.3d 560, 572 (8th Cir. 2002). In so doing it constructed a three-part test to review involuntary medication orders for procedural due process that failed to account for how the effects of involuntary medication occasion several forms of trial prejudice. *Id.* at 567-568.

LOJRS suggests that because the intended governmental action in this case infringes on a clearly established fundamental right, it must be reviewed under a strict scrutiny standard rather than the *Sell* court's three-part test. In holding that the government can forcibly medicate a pretrial detainee for the sole purpose of rendering him competent to stand trial, the Court of Appeals for the Eighth Circuit has improperly balanced Dr. Sell's right to bodily integrity and liberty interest in refusing unwanted medication against the government's interest in bringing him to trial. The *Sell* court failed to recognize that in this case petitioner's liberty interest in avoiding unwanted medication is more than merely "significant." *Id.* at 565. Since the liberty interest in refusing unwanted medication derives from the right to bodily integrity, it is *fundamental* and protected under the due process clauses of the Fifth and Fourteenth Amendments. Because the *Sell* court did not recognize the right in question to be a fundamental one, it failed to apply strict scrutiny and applied an erroneous lower standard of review instead.

When reviewed under a strict scrutiny standard the government's attempt to circumvent the proscription on trying an incompetent defendant with mind-altering medication fails to evince a policy narrowly tailored to a compelling interest that outweighs petitioner's fundamental right. For this reason LOJRS respectfully requests that the petition be granted.

ARGUMENT

I. The Right to Bodily Integrity is a Clearly Established Fundamental Right Guaranteed by the Due Process Clause of the Fifth and Fourteenth Amendments that Encompasses the Right to Refuse Unwanted Psychotropic Medication.

The text of the Constitution does not expressly protect against forcible intrusions of the human body such as the non-volitional administration of psychotropic drugs by injection. Yet it is well settled that the Due Process Clause of the Fourteenth Amendment clause provides substantive protection for rights that have no textual support in the Constitution. *Planned Parenthood v. Casey*, 505 U.S. 833, 847-48 (1992). This substantive component bars certain government actions under certain circumstances regardless of the fairness of the procedures used to implement them, *Washington v. Glucksberg*, 521 U.S. 702, 719 (1997) (quoting *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992)), and provides heightened protection against governmental interference with certain fundamental rights and liberty interests. *Id.* at 720.

Whether substantive due process protects a particular liberty interest is determined by an inquiry into whether the right in question is fundamental. "The determination of whether a right is fundamental begins with an examination of the teachings of history and solid recognition of the basic values that underlie our society." *Bee v. Graves*, 744 F.2d 1387, 1392 (10th Cir. 1984) (citations omitted).

Traditionally, rights deserving of substantive protection are those that relate to "freedom of action in a sphere contended to be 'private.'" *Paul v. Davis*, 424 U.S. 693, 713, (1976). This Court has held that such "private" rights include the right to marriage (*Loving v. Virginia*, 388 U.S. 1 (1967)),

to procreation (*Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942), to make decisions about the education and upbringing of one's children (*Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925)), to use contraception (*Griswold v. Connecticut*, 381 U.S. 479 (1965), and to abortion (*Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood, supra)*. Although these fundamental rights pertain to personal matters, the court has not necessarily subsumed them under the right to privacy. In *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), the Court suggested that refusing unwanted lifesaving medical treatment, although traditionally found to be encompassed by a generalized constitutional right to privacy by many state courts, was an issue more properly analyzed in terms of a Fourteenth Amendment liberty interest. *Id.* at 279 n.7.

This Court has also recognized that "bodily integrity", or the right to control one's own body and make decisions affecting it, is part of this substantive protection. *Planned Parenthood, supra* at 915-916, (Stevens, J., concurring in part, dissenting in part.); *see also Washington v. Glucksberg, supra*, at 720; *Albright v. Oliver*, 510 U.S. 266, 272 (1994).) The ability to decide for oneself those matters affecting one's body and mind is one of the most valued liberties in a civil society. Indeed, "our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination." *Cruzan, supra*, at 287 (O'Connor, J., concurring.)

Our common law has long accorded protection to the right of self-determination in questions of medical treatment. The principle of informed consent rests upon the recognition of the right of every human being to determine what shall be done with his own body. *In re Cincinnati Radiation Litigation*, 874 F. Supp. 796, 816 (S.D. Ohio, 1995). Thus the tort of battery includes medical procedures performed

on patients without their consent. *See, e.g.*, W.E. Shipley, Annotation, *Liability Of Physician Or Surgeon For Extending Operation Or Treatment Beyond That Expressly Authorized*, 56 A.L.R.2d 695 (1957); Restatement (Second) of Torts § 53 cmt. a, illus. 3 (1965).

The contours of the right to be free from bodily intrusion have developed over a long line of cases involving non-consensual invasive medical procedures[4]. In *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250 (1891), this Court ruled that a court could not order someone to submit to a non-consensual surgical examination, stating,

> No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint and interference of others, unless by clear and unquestionable authority of law . . . "The right to one's person may be said to be a right of complete immunity: to be let alone."

Id. at 251, *quoting* Cooley on Torts, 29.

In *Skinner v. Oklahoma ex rel. Williamson*, *supra*, this Court struck down a statute that mandated the sterilization of habitual criminals, finding that elementary notions of due process would require the state to take appropriate steps to safeguard the liberty of the individual by affording him procedural due process before "he is condemned to an irreparable injury to his person." *Id.* at 545 (Stone, J., concurring).

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4. For the detailed analysis of this issue see Morris L. Hawk, *The 'Kingdom of Ends': In re Cincinnati Radiation Litigation and the Right to Bodily Integrity*, 45 Case W. Res. 997 (1995).

Perhaps the most notorious of these cases, *Rochin v. California*, 342 U.S. 165 (1952), involved the non-consensual stomach pumping of a man suspected of ingesting morphine capsules after the police had tried, but failed, to wrest them from his throat. Justice Frankfurter explained that regard for the requirements of the Due Process clause impose upon the Court a duty to review criminal proceedings to ascertain whether they offended "those canons of decency and fairness which expressed the notions of justice of English-speaking peoples even toward those charged with the most heinous offenses." *Id.* at 169. He concluded that the police invasion of the defendant's body "shocked the conscience":

> Illegally breaking into the privacy of the petitioner, the struggle to open his mouth and remove what was there, the forcible extraction of his stomach's contents — this course of proceeding by agents of government to obtain evidence is bound to offend even hardened sensibilities. They are methods too close to the rack and the screw to permit of constitutional differentiation.

Id. at 172.

Even so, not all medical procedures invasive of bodily integrity have been found to violate due process. This court has twice found that some minimal invasions, in specific contexts, do not offend due process. For example, compulsory vaccinations for smallpox were upheld in *Jacobsen v. Massachusetts*, 197 U.S. 11 (1905). The defendant in *Jacobsen* challenged a Massachusetts statute that called for the vaccination of all fit adults on the grounds that it invaded his liberty and his inherent right to "care for his own body and health in such a way as to him seems best" and therefore was "nothing short of an assault upon his person." *Id.* at 26.

The Court acknowledged that:

> [t]here is, of course, a sphere within which the individual may assert the supremacy of his own will and rightfully dispute the authority of any human government, especially of any free government existing under a written constitution, to interfere with the exercise of that will

Id. at 29.

Nevertheless, the Court found that the individual's will was outweighed by the state's need to prevent a smallpox epidemic, but noted that its result might have been different if the vaccination had *seriously impaired* the petitioner's health. *Id.* at 39 (emphasis added).

In *Schmerber v. California*, 384 U.S. 757 (1966), the court upheld a compelled blood alcohol content test of an automobile accident victim for the purpose of collecting evidence of a crime. *Compare Winston v. Lee*, 470 U.S. 753 (1985) (holding that the government may not compel surgery for the removal of a bullet from a defendant's body for the same purpose where alternative means exist). A police officer ordered that a blood sample be taken when the victim was unconscious in the emergency room. The Court noted that the bodily intrusion in *Schmerber* was minor because the test collected a minimal amount of blood and involved "virtually no risk, trauma, or pain." *Id.* at 771. But it still carefully limited its holding to the particular facts of the case, and emphasized that:

> [t]he integrity of the individual's person is a cherished value of our society. That we hold today that the Constitution does not forbid the state's minor intrusions into an individual's body under strictly limited conditions *in no way indicates that it permits more substantial intrusions or intrusions under other conditions.*

Id. at 771-772 (emphasis added.)

It should be borne in mind that Dr. Sell has not been declared incompetent to handle his own affairs, but rather has merely been found incompetent to stand trial because he suffers from delusional disorder of the persecutory variety. Whether forcible medication would restore his competency to stand trial is not knowable with any degree of certainty; what is known, at best, is that antipsychotic medication may suppress the symptoms of his illness[5]. However, use of these medications involves substantial risk of dangerous side effects that include permanent physical impairment and possibly death[6]. Like all competent adults he retains the right to make his own determinations regarding the risks inherent in any medical treatment. His right is not diminished by the fact that he is being held to answer for a crime.

As was the case with the defendant in *Skinner*, the proposed course of treatment in the instant case subjects Dr. Sell to the risk of irreparable injury to his person[7]. The injection will likely be administered by force, with staff at the government psychiatric facility holding him down while government doctors drive the needle into his body.

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5. Antipsychotic medication does not "cure" mental illness; It suppresses symptoms of psychoses such as hallucinations, delusions, and paranoid ideation. (*See*, e.g., Thomas G. Guthiel and Paul S. Appelbaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 Hoftstra L. Rev. 77, 101 (1983).) Once a regimen of antipsychotics is discontinued, symptoms are likely to recur. *Ibid.*

6. *See* footnote 3 above.

7. *Ibid.*

The struggle to medicate him, like the struggle in *Schmerber*, is an unnecessarily brutal act. The fact that such an act would so readily be visited upon on a non-violent pre-trial detainee charged with a non-violent crime, challenges the concept of fairness we would extend even to those charged with greater offenses.

Unlike the invasion of the body with a syringe containing relatively benign inoculants or with an empty syringe for drawing a small sample of blood, the forced injection of anitipsychotic medication is not free from trauma or indignity. Given that Dr. Sell's has thus far received no treatment for his condition, such an act is likely to aggravate his paranoia. Considering the side effect profile of the medication, it cannot be said to be free of serious impairment. But the feature that most distinguishes the forcible administration of medicine in this case to the injections in *Jacobsen* and *Schmerber* is that in those cases there was a clear public safety rationale offered for weighing the balance of interests in the government's favor. Vaccinations are sometimes required to prevent deadly epidemics and investigating and prosecuting drunk driving cases serves the function of reducing accidents. No such compelling safety justification exists in the instant case. The Court of Appeals for the Eighth circuit affirmed the district court's finding that Dr. Sell posed no danger to himself or others. *Sell*, *supra*, at 565. He is not violent and the medication is not required to better manage his detainment.

A long line of constitutional jurisprudence and, even before it, strong common law traditions uphold Justice's Steven's assertion that the "liberty interest of citizens to resist the administration of mind altering drugs arises from our Nation's most basic values." *Washington v. Harper*, 494 U.S. 210 (1990) (Stevens, J., dissenting). Dr. Sell asserts the right to refuse the invasion of his person via the forcible administration of psychotropic medication, under the due

process clause of the Fifth and Fourteenth Amendments. This court has held that individuals possess "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the due process clause of the Fourteenth Amendment" (*Id.* at 221-222.) and that far from being minimal, the "forcible injection of medication into a non-consenting person's body represents a substantial interference with that person's liberty" (*Id.* at 229.)

The fundamental rights of pretrial detainees "still cloaked with the presumption of innocence" are not of a smaller degree than those of free citizens. *Sell*, *supra*, at 574 (Bye, J., dissenting). To argue that the proposed course of action in this case would violate Dr. Sell's right to bodily integrity *is not* a suggestion that the government cannot constitutionally restrain his liberty by detaining his person. The presumption of innocence afforded pretrial detainees does not immunize them from the reasonable restraints of their confinement. *Bell v. Wolfish*, 441 U.S. 520, 534 (1979). Rather, LOJRS submits that the government may restrain his liberty no further in this instance by invading it through the non-consensual administration of psychotropic medicine.

II. The Forcible Administration of Psychotropic Drugs for the Sole Purpose of Rendering a Pretrial Detainee Competent to Stand Trial is a Governmental Action Infringing on the Fundamental Right to Bodily Integrity and Must be Subject to Strict Scrutiny.

There can be no doubt that a right is infringed when its exercise is prohibited. Erwin Chemerinsky, *Constitutional Law: Principles and Policies*, 2d ed., at 766 (2002). Where a person is physically restrained to overcome his resistance to a medical procedure, as Dr. Sell will eventually be if the decision below is affirmed, he is effectively prevented from exercising his right to refuse that procedure. "Government action that infringes a fundamental right will survive a

substantive due process challenge only if it can survive strict scrutiny, i.e., if it is narrowly tailored to a compelling government interest." *United States v. Brandon*, 158 F.3d 947, 956 (6th Cir. 1998), *citing Roe v. Wade*, 410 U.S. 113, 154 (1973).

In *Brandon*, the Sixth Circuit Court of Appeals held that where the government seeks to forcibly medicate a pretrial detainee for the sole purpose of rendering him competent to stand trial, the proposed action infringes the detainee's fundamental right to be free from bodily intrusion, and must therefore be subject to strict scrutiny. *Id.* at 957, *citing Bee v. Graves*, *supra*, 744 F.2d at 1395. The *Brandon* court was careful to note that its determination did not conflict with this Court's application of the rational basis standard in *Washington v. Harper*, 494 U.S. at 238, because *Harper* involved an incarcerated felon rather than a pretrial detainee, and the decision's rationale was based upon the premise that the government's action was justified by concerns over prison administration, whereas in *Brandon* the sole justification related to trial administration.

The *Brandon* court found it was not bound by the one Supreme Court decision to review the forcible medication of a pretrial detainee, *Riggins v. Nevada*, 504 US 127 (1992). In *Riggins* this court used language suggestive of strict scrutiny in dicta[8], but it expressly refrained from adopting a substantive standard because that question was not before it. *Id.* at 136.

This case presents a situation never before addressed by this court, and one which threatens to misread and grossly extend this court's holdings in *Harper* and *Riggins*. Unlike in *Harper*, the Government does not seek to justify the

8. The Court alluded that the district court would have satisfied due process in its decision to medicate Riggins if it had considered "less restrictive means". *Id.* at 135.

forcible drugging of Dr. Sell with reasons relating to penological concerns such as safety. The Eighth Circuit's holding approves the forced drugging of Dr. Sell because that court failed to distinguish the rights of a pretrial detainee from those of a convicted inmate, and consequently failed to apply the correct standard of scrutiny. It further misread *Riggins* to mean that strict scrutiny was not required. Finally, rather than follow the substantive standard previously prescribed for the medication of a non-violent pretrial detainee by a sister circuit, it relied on the holdings of lower courts and constructed a convoluted three-part test that will only promote further non-uniform application of the law with respect to forced medication. *Sell*, *supra*, at 567-568.

By granting the petition in the instant case, this court now has the important opportunity it lacked in *Riggins* to prescribe a substantive standard for the forcible medication of non-violent pretrial detainees.

III. The Government's Attempt to Forcibly Medicate Dr. Sell with Psychotropic Drugs is Insufficiently Tailored to Its Interest in Conducting Fair Trials.

The court below recognized that the government has an essential interest in bringing a defendant to trial, which is "fundamental to a scheme of ordered liberty and a prerequisite to social justice and peace." *Sell*, *supra*, at 568, *quoting Illinois v. Allen*, 397 U.S. 210 (1970) (Brennan, J., concurring.) The constitutional guarantee of a fair trial for those accused of a crime (U.S. Const. Amend. VI) is likewise fundamental to an ordered scheme of liberty. It ensures that persons shall not be convicted of crimes without adequate opportunity to defend themselves. Dora W. Klein, *Trial Rights and Psychotropic Drugs: The Case Against Administering Involuntary Medications to a Defendant During Trial*, 55 Vand. L. Rev. 165, 189-190 (2002). The Sixth Amendment also grants several specific procedural

rights including the right to be tried by an impartial jury, to confront and present witnesses, and to receive effective assistance of counsel. *Id.* at 190. The proscription against trying the incompetent is one of several judicial interpretations of the fair trial guarantee that give it meaning and effect in practice. *Pate v. Robinson*, *supra*, at 378. Another is the right to be present at trial. *Snyder v. Massachusetts*, 291 U.S. 97, 105-106 (1934) (finding the privilege guaranteed by the Fourteenth Amendment).

It is the inherent inequity in trying the incompetent that drives the controversy in this context, and requires that incompetent defendants be restored to competency if a trial is to proceed at all. Whether the Government's proposed action of medicating Dr. Sell in order to restore his competence to stand trial is narrowly tailored to its interest will turn, as the *Brandon* court suggested, on "whether that action is the least restrictive and least harmful means of satisfying the government's goal . . . of rendering [the accused] competent to stand trial in a proceeding that is *fair to both parties*." *Brandon*, *supra*, at 960 (emphasis added).

While the forcible physical invasion of Dr. Sell's body with medication raises serious concerns about fair treatment in and of itself, the effects of forcible medication have been recognized to interfere with the exercise of procedural and other fundamental rights at trial.

> Psychotropic drugs can interfere with a defendant's ability to exercise procedural rights by causing sedation, producing feelings of restlessness and anxiety, diminishing awareness of and interest in the surrounding environment, disrupting memory, and inducing all manner of motor disturbances . . . [They] are also likely to impair many abilities necessary for presenting a defense, including the ability to pay attention to

> what witnesses, or the attorneys, or anyone else in the courtroom is saying; to offer comments or suggestions or otherwise engage in dialogue about the trial; to understand and respond to questions while testifying; and even to decide whether to testify. By administering involuntary antipsychotic medications, the government interferes with the defendant's general right to be present, as well as with his more specific rights to receive effective assistance of counsel, to confront witnesses, to present evidence, and to testify on his own behalf.

Klien, *supra*, at 191. *See, e.g.*, *Bee v. Graves*, *supra*, at 1392 (Antipsychotic drugs have the capacity to severely and permanently affect an individual's ability to think and communicate, thereby affecting First amendment right to free thought and speech); *Riggins v. Nevada*, *supra*, at 137-138 (Expert testimony regarding effect of antipsychotic medication cannot cure possibility that thought process, participatory ability, or demeanor were affected at trial, thereby infringing the First Amendment right to free thought and speech and the Sixth Amendment right to fair trial.); and *United States v. Brandon*, *supra*, at 953-954 (Recognition that forced medication implicates First, Fifth, and Sixth Amendment rights at trial). It has also been suggested that medicating defendant for the express purpose of altering his brain chemistry raises the same fundamental fairness concerns as when it is alleged that the prosecution has manipulated material evidence. *Riggins*, *supra*, at 139 (Kennedy, J., concurring).

Every time the government seeks to involuntarily medicate a pretrial detainee in order to attempt to render him competent to stand trial, it not only invades the integrity of his body, it creates substantial risk that defendant's constitutional right to a fair trial will be violated. Some courts have suggested that curative measures including jury

instructions about the effects of the medication sufficiently address the threat to defendant's trial rights. *United States v. Weston*, 255 F.3d 873, 886 (D.C. Cir. 2001). Putting aside the possibility that such an announcement would create an atmosphere where the stigma associated with psychiatric medication prejudices the jury's view of the defendant, curative instructions can only be applied to those potential inequities that are clearly recognized. Medication creates a risk of altering a defendant's cognition and therefore his behavior at trial in ways that cannot be detected, much less reviewed on appeal should such prejudice be claimed after conviction:

> The avowed purpose of the medication is not mere functional competence, but rather competence to stand trial . . . elementary protections against state intrusion require the state in every case to make a showing that there is no significant risk that the medication will impair or alter in any material way the defendant's capacity or willingness to react to the testimony at trial or to assist his counsel. Based on my understanding of the medical literature, I have substantial reservations that the state can make that showing. Indeed, the inquiry itself is elusive, for it presupposes some baseline of normality that experts may have some difficulty in establishing for a particular defendant, if they can establish it at all.

Riggins, *supra*, at 141 (Kennedy, J., concurring).

Governmental purpose "cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved." *Bee v. Graves*, *supra*, at 1396 (*quoting Shelton v. Tucker*, 364 U.S. 479, 488 (1960)). Here, the government would attempt to address one aspect of inequity in a given judicial proceeding by means that restrict the exercise of enumerated constitutional rights and introduce other forms of prejudice into the trial. Rendering an incompetent defendant

such as Dr. Sell competent to stand trial by forcibly medicating him with drugs that would create a condition wherein several other fundamental rights were prejudiced, is not the least restrictive means of rendering him competent to stand trial.

Less restrictive means to achieve the government's purpose exist. As the dissent in the court below noted, Dr. Sell will not go free if he does not stand trial. He can be civilly committed until he is rendered competent through other forms of treatment or until he agrees to take psychotropic drugs voluntarily. *United States v. Sell*, *supra*, at 574 (Bye, J., dissenting.) Psychiatric treatment without antipsychotic medication or treatment wherein medication is voluntarily taken can also restore competency without raising concerns about trial prejudice. In the instant case, Dr. Sell's psychiatrist has recommended such a course of treatment, along with access to reading materials and opportunity to exercise, but the doctors at the government's psychiatric facility at Springfield have not attempted to treat him by any means other than antipsychotic medication. For these reasons, the government's action is not sufficiently tailored to its underlying compelling interest in the fair adjudication of criminal trials.

Dr. Sell's commitment without treatment has now continued for a period of time almost equal to that he would have to serve in prison if convicted of the crimes he is charged with. It should not be forgotten that defendants have as much of an interest in proceeding to trial for an opportunity to be acquitted of charges as the government does in bringing them there in the hopes of attaining a conviction. Prolonged civil commitment may ultimately prove more costly than a syringe full of antipsychotic medication and the expedited trial of a complacently sedated defendant, but as Justice Stevens noted in *Riggins*, "the Constitution requires that society bear this cost in order to preserve the integrity of the trial process." *Riggins*, *supra*, at 145 (Stevens, J., concurring).

CONCLUSION

For the foregoing reasons, *amicus curiae* respectfully urges the Court to grant the petition for certiorari.

Respectfully submitted,

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In The
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DR. CHARLES THOMAS SELL,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF THE NATIONAL ASSOCIATION OF CRIMINAL DEFENSE LAWYERS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF *AMICUS*[1]

The National Association of Criminal Defense Lawyers ("NACDL") is the preeminent organization in the United States advancing the mission of America's criminal defense lawyers to ensure justice and due process for persons accused of crime or other misconduct. A professional bar association founded in 1958, NACDL's more than 10,400 direct members – and more than 80 state and local affiliate organizations with another 28,000 members – include private criminal defense lawyers, public defenders, active U.S. military defense counsel, law professors, and judges committed to preserving fairness within America's criminal justice system. The American Bar Association recognizes NACDL as an affiliate organization with full representation in its House of Delegates.

NACDL promotes study and research in the field of criminal law to disseminate and advance knowledge of the law in the area of criminal practice. NACDL seeks to defend individual liberties guaranteed by the Bill of Rights and has a keen interest in ensuring that legal proceedings are handled in a proper and fair manner. Among NACDL's objectives is promotion of the proper administration of justice. In furtherance of that objective, over the last

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[1] Pursuant to this Court's Rule 37.2(a), letters of consent from both parties to the filing of this brief have been filed with the Clerk. Pursuant to this Court's Rule 37.6, counsel represent that this brief was not authored in whole or in part by counsel for any party, and that no person or entity other than amicus, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

decade, NACDL has filed approximately ten *amicus* briefs per year with this Court on criminal justice related issues.

SUMMARY OF THE ARGUMENT

Both the Fifth and Sixth Amendments establish Dr. Sell's right to testify regarding his diminished capacity at the time of the alleged criminal activity. Accordingly, this Court should reverse due to the Eighth Circuit's failure to adequately consider the preeminent import of this and other clearly established constitutional rights implicated by the government's forced medication of Dr. Sell.

ARGUMENT

I. Dr. Sell Has A Constitutional Right To Present Evidence Of His Diminished Capacity.

In allowing the forcible medication of Dr. Sell, the Eighth Circuit offered only cursory analysis of the constitutional implications of this government action. *United States v. Sell*, 282 F.3d 560, 571-72 (8th Cir. 2002). Mentioning only the possible interference with Dr. Sell's demeanor and ability to assist counsel at trial, the Court of Appeals ignored a host of long-recognized constitutional rights compromised by his forced medication, in particular, Dr. Sell's rights to present a defense and to testify on his own behalf. Firmly grounded in the Fifth and Sixth Amendments, these two rights give rise to Dr. Sell's constitutionally protected right to present a "diminished capacity defense," *i.e.*, the right to present his own unfettered testimony regarding his state of mind at the time of the alleged criminal activity.

A. Diminished Capacity Is An Evidentiary Concept, Not An Affirmative Defense.

The term "diminished capacity defense" is a misnomer that has fostered some confusion within case law, often through the confounding of two distinct concepts. First, "diminished responsibility," an affirmative defense widely accepted only in European countries, "permits the jury to mitigate the punishment of a mentally disabled but sane offender in any case where the jury believes that the defendant is less culpable than his normal counterpart who commits the same criminal act." *United States v. Pohlot*, 827 F.2d 889, 904 (3d Cir. 1987). In contrast, "diminished capacity" is not an affirmative defense at all, but instead refers to the defendant's introduction of evidence of a mental disorder as a means of negating *mens rea*. Dr. Sell wishes to protect his right to present evidence under this second concept, which is widely accepted in our federal common law. *See, e.g.*, *United States v. Gonyea*, 140 F.3d 649, 651 (6th Cir. 1998); *United States v. Fazzini*, 871 F.2d 635, 641 (7th Cir. 1989); *United States v. Twine*, 853 F.2d 676, 678 (9th Cir. 1988); *Pohlot*, 827 F.2d at 896. As one leading commentator further elaborates:

> [T]he *mens rea* variant of diminished capacity is not a separate defense that deserves to be called "diminished capacity" or any other name connoting that it is some sort of special, affirmative defense. The defendant is simply introducing evidence, in this case evidence of mental abnormality, to make the following claim: "I did not commit the crime charged because I did not possess the requisite *mens rea*." This is not an affirmative defense whereby the defendant admits or has proved against him the elements of the crime charged, but then raises a claim of justification or

> excuse. Further, a defendant claiming no *mens rea* because of mental disorder is not asserting some lesser form of legal insanity, that is, he is not claiming that he is partially or less responsible for the crime charged. Rather, the defendant is straightforwardly denying the prosecution's *prima facie* case by attempting to cast doubt on the prosecution's claim that a requisite mental element was present at the time of the offense.

Stephen J. Morse, *Undiminished Confusion in Diminished Capacity*, 75 J. Crim. L. & Criminology 1, 6 (1984).

B. Dr. Sell's Right To Present Evidence Of Diminished Capacity Rests In The Fifth And Sixth Amendments.

In reversing the Eighth Circuit, this Court should recognize the constitutional underpinnings of Dr. Sell's right to present evidence of his diminished capacity. Indeed, this right is a logical extension of several long-recognized rights under our Constitution. First, the Sixth Amendment protects Dr. Sell's right to present his own defense. *Faretta v. California*, 422 U.S. 806, 819 (1975). Second, both the Fifth and Sixth Amendments provide his right to testify on his own behalf, *i.e.*, Dr. Sell's fundamental right "to present his *own* version of events in his *own* words." *Rock v. Arkansas*, 483 U.S. 44, 51-52 (1987) (emphasis added). Third, this Court has recognized that the right to testify is of greatest constitutional significance where, as here, the accused potentially seeks to testify regarding his lack of the requisite *mens rea* necessary for conviction. *Crawford v. United States*, 212 U.S. 183, 202-203 (1909); *United States v. Hayes*, 477 F.2d 868, 873 (10th Cir. 1973) ("Where a defendant's intent is in issue he

should be permitted to testify as to his motive and actual intent or state of mind."); *United States v. Edwards*, 458 F.2d 875, 884 (5th Cir. 1972) ("[W]e think justice would require that the defendant be given an opportunity to take the stand and state to the jury that he intended no wrongdoing."); *Krogmann v. United States*, 225 F.2d 220, 229 (6th Cir. 1955) ("[T]he rule is well settled that in a criminal proceeding where the intent of the defendant is in issue the defendant may testify as to what his intent was."). Dr. Sell's presentation of a diminished capacity defense – that is, offering his own defense through his testimony regarding the most critical element of the government's case – flows directly from this bundle of rights.

II. The Eighth Circuit's Opinion Violates Dr. Sell's Right To Present Evidence Of His Diminished Capacity.

This Court should reverse the Eighth Circuit's opinion for failing to even address, let alone appropriately analyze, the significance of the Fifth and Sixth Amendment rights discussed above. The Eighth Circuit's opinion stands in contradiction with *Rock v. Arkansas*' constitutional mandate of allowing Dr. Sell to present "his *own* version [of his state of mind] in his *own* words." Without reiterating the numerous and significant effects of psychotropic medication, *Riggins v. Nevada*, 504 U.S. 127, 134, 141-144 (1992) (Kennedy, concurring), the government's forced administering of these drugs would affect, *inter alia*, Dr. Sell's abilities to "understand and respond to questions while testifying" and to describe the nature and extent of his delusional disorder. Dora W. Klein, *Trial Rights and Psychotropic Drugs: The Case Against Administering Involuntary*

Medications to a Defendant During Trial, 55 Vand. L. Rev. 165, 199 (2002). Indeed, psychotropic medication may affect his ability to actually decide to testify in the first instance. *Id.* at 191.

Under the Eighth Circuit's opinion, the government will compel the administering of psychotropic drugs to Dr. Sell and bring him to trial, where he would perhaps take the stand to testify. Yet, in contravention of this Court's precedents, his words would not be his own. They would be the government's.

CONCLUSION

For the foregoing reasons, this Court should reverse.

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In The

Supreme Court of the United States

DR. CHARLES THOMAS SELL, D.D.S.,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Eighth Circuit

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QUESTION PRESENTED

1. Whether the Court of Appeals erred in rejecting petitioner's argument that allowing the government to administer antipsychotic medication against his will solely to render him competent to stand trial for non-violent offenses would violate his rights under the First, Fifth, and Sixth Amendments?

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INTEREST OF AMICUS CURIAE[1]

The ACLU of Eastern Missouri is the local affiliate of the American Civil Liberties Union with 2,500 members and its principal place of business in St. Louis, Missouri. As part of its mission, the ACLU of Eastern Missouri has participated in numerous cases supporting individuals' First, Fifth, and Sixth Amendment interests, including our participation in this case below as *amicus curiae*.

SUMMARY OF THE ARGUMENT

The Petitioner, Dr. Charles T. Sell, challenges a pre-trial determination that the government has the power to inject him with potentially dangerous and medically inappropriate antipsychotic drugs against his will solely to render him competent to stand trial for non-violent offenses. At issue in this case is nothing less than whether an individual has the right to make medical decisions affecting his body and mind.

The right of each person to determine his or her medical treatment is one of the most valued liberties in a democratic society. The liberty interest to bodily integrity in medical decisions has long been recognized by common law and under the Constitution. This Court has recognized

[1] Pursuant to Rule 37.2(a), letters of consent from both parties have been filed with the Clerk. Pursuant to Rule 37.6, counsel represent that this brief was not authored in whole or in part by counsel for any party and that no person or entity other than *amici*, their members, or counsel made a monetary contribution to preparing or submitting this brief.

the important Constitutional protections of personal autonomy and bodily integrity in decisions relating to procreation, contraception, refusal or termination of medical treatment (including life-saving medical treatment), and a criminal defendant's right to refuse unwanted antipsychotic medication prior to and during trial.

In upholding the trial court's decision, a split panel of the Court of Appeals for the Eighth Circuit failed to consider Dr. Sell's First and Fifth Amendment interests to be free from the government's control of his thoughts, emotions, and ability to communicate with his lawyers. The court below also failed to weigh properly Dr. Sell's liberty interest in bodily integrity against the government's interest in injecting him with antipsychotic drugs against his will solely to attempt to render him competent to stand trial for non-violent offenses.

More particularly, in reaching its decision, the court below failed to follow the test developed in *Riggins v. Nevada*, 504 U.S. 127 (1992). *Riggins* established a three-part test the government must meet before it may override the liberty interest of a person awaiting trial to be free from forced medication: 1) the treatment with antipsychotic medication is "medically appropriate," 2) there are no "less intrusive alternatives," *and* 3) the antipsychotic medication is either "essential for the sake of . . . [the defendant's] own safety or the safety of others" or there are other "compelling" reasons justifying forced medication. *Riggins*, 504 U.S. at 135-136. Although acknowledging the *Riggins* test, the court below failed to consider less intrusive alternatives to achieve the government's interest. Moreover, it specifically found that Dr. Sell posed no danger to himself or others, and it did not identify compelling

reasons justifying the forced medication order issued by the trial court.

These conclusions fatally undermine the court's holding. On this record, the government has simply not met its burden of proving a sufficient interest for violating Dr. Sell's liberty interest to be free from psychotropic drugs. For these reasons, the court ordered forcible medication of Dr. Sell should be overturned.

ARGUMENT

I. The Petitioner Has A Liberty Interest To Bodily Integrity, Protected By The First And Fifth Amendments Of The Constitution, That Prohibits The Government From Injecting Him With Antipsychotic Drugs Against His Will Solely To Render Him Competent To Stand Trial For Non-Violent Offenses.

This Court has long recognized that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891). In numerous cases over the years, this Court has repeatedly found that the Constitution protects individuals from government control of decisions affecting bodily integrity. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 849 (1992) ("It is settled now . . . that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as

bodily integrity.") (citations omitted). There are two interrelated components of the liberty interest to bodily integrity which strongly support a finding of constitutional protection to make medical decisions prohibiting the government from injecting Dr. Sell with potentially harmful antipsychotic drugs against his will solely to render him competent to stand trial for non-violent offenses.

The first component of the liberty interest in bodily integrity protects the individual's interest in decisional autonomy – the freedom to make decisions concerning his or her life free from significant government interference. *See Walen v. Roe*, 429 U.S. 589 (1977); *Roe v. Wade*, 410 U.S. 113 (1973); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Loving v. Virginia*, 388 U.S. 1 (1967); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Prince v. Massachusetts*, 321 U.S. 158 (1944). In *Casey*, this Court explained: "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." 505 U.S. at 851.

The second component of the liberty interest to bodily integrity is explicitly found in this Court's cases involving a person's right to make medical decisions. In *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), this Court reasoned that the right to bodily integrity is embodied in the general requirement of informed consent for medical treatment, and that "[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is to refuse treatment." *Id.* at 269. This Court found that "a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at

278. The right to refuse medical treatment is grounded in the notion of liberty that is "inextricably entwined with our idea of physical freedom and self-determination." *Id.* at 287 (O'Connor, J., concurring).

Whenever medical treatment is imposed contrary to a person's consent, this Court has recognized an interference with the person's liberty interest that must be balanced against the government's interest in seeking to infringe upon the right to bodily integrity. *See, e.g.*, *Vitek v. Jones*, 445 U.S. 480, 494 (1980) (finding that involuntarily psychiatric treatment and behavior modification of an alleged mentally unstable prisoner constitutes "deprivations of liberty that requires procedural protections"); *Parham v. J.R.*, 442 U.S. 584, 600 (1979) ("It is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment. . . ."); *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 (1905) (finding that the state's interest in public health and safety was sufficient to override the individual's liberty interest to resist vaccination); *Riggins*, 504 U.S. at 135-36 (establishing three-part test government must meet before it may override an individual's liberty interest to be free from forced medication).

The fact that Dr. Sell has been found not competent to stand trial does not establish that the government may deny his right to make medical decisions for himself. Indeed, Dr. Sell has not been adjudicated incompetent to make medical decisions on his own behalf. Although this Court has never squarely decided the extent of the constitutional protections for persons not considered competent, it has recognized that the mentally ill and persons not deemed competent still enjoy liberty interests of bodily integrity. *See, e.g.*, *Youngberg v. Romero*, 457 U.S. 307, 315-316 (1982)

(holding that a profoundly retarded person still has constitutionally protected interests in personal safety and freedom from bodily restraint). In considering the extent of the liberty interest to bodily integrity in the context of forcibly administering antipsychotic medication, this Court has recognized that a mentally ill convicted prisoner possesses "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs" and "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." *Washington v. Harper*, 494 U.S. 210, 221-222, 229 (1990). Thus, Dr. Sell's liberty interests provide him with protection against government forcibly injecting him with antipsychotic drugs.

A. The Forcible Medication Of The Petitioner With Antipsychotic Drugs Infringes On His First Amendment Interests.

The government's intention to inject Dr. Sell with antipsychotic drugs with the express aim of controlling his thought processes, emotions, and ability to concentrate and communicate with his lawyers intrudes on Dr. Sell's First Amendment rights. The First Amendment provides, in pertinent part: "Congress shall make no law . . . abridging the freedom of speech. . . ." U.S. CONST. amend. I. This Court has interpreted the "freedom of speech" clause to include rights deemed essential to free speech, such as the "freedom of the mind." *See, e.g., Abood v. Detroit Bd. of Educ.*, 431 U.S. 209, 234-235 (1977) ("For at the heart of the First Amendment is the notion that an individual should be free to believe as he will, and that in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State.").

Forced medication may permanently distort the thought process of pretrial detainees, depriving them of their liberty interests including the freedom from intrusion and control of the government into and over their minds.

This Court has recognized that freedom of thought is central to the First Amendment. *Wallace v. Jaffree*, 472 U.S. 38, 50 (1985) (an "individual's freedom of conscience [is] the central liberty that unifies the various clauses of the First Amendment."). In *Stanley v. Georgia*, 394 U.S. 557 (1969), this Court found that individuals were entitled to First Amendment protection from intrusions into their minds:

> The makers of our Constitution . . . recognized the significance of man's spiritual nature, of his feelings and of his intellect. [They] sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone – the most comprehensive of rights and the right most valued by civilized men."

Stanley, 394 U.S. at 565-566 (quoting *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting). While *Stanley* addressed a constitutional right to possess obscene material, this Court's decision in that case recognized a broader liberty interest to be free from government interference with the workings of one's mind. This Court observed: "Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds." *Stanley*, 394 U.S. at 565.

Several Circuit Courts have found this principle applicable to the forced medication of pre-trial defendants.

Although this Court has not directly considered the nature of the First Amendment freedom of the mind when the government seeks to alter a person's mind with antipsychotic drugs, some Circuit Courts have found that forced medication of pretrial detainees like Dr. Sell affects their ability to produce ideas in violation of their First Amendment right to freedom of speech. In *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985), a unanimous panel of the Tenth Circuit found that "[t]he First Amendment protects the communication of ideas, which itself implies protection of the capacity to produce ideas." *Id.* at 1393-1394. The court further found that "[a]ntipsychotic drugs have the capacity to severely and even permanently affect an individual's ability to think and communicate," and thus implicate rights protected by the First Amendment. *Id.* at 1394. Relying in part on this Court's First Amendment analysis that the government cannot have the power "to control men's minds," *Stanley*, 394 U.S. at 565, the court in *Greaves* concluded that a pretrial detainee "retains a liberty interest derived from Constitution in avoiding unwanted medication with [antipsychotic] drugs." 744 F.2d 1394.

More recently, a unanimous panel of the Sixth Circuit found that a pretrial detainee "has a First Amendment interest in avoiding forced medication, which may interfere with his ability to communicate ideas." *U.S. v. Brandon*, 158 F.3d 947, 953 (6th Cir. 1998) (citing *Greaves*, 744 F.2d at 1393). Similarly, Dr. Sell has argued that he has a First Amendment interest in avoiding forced medication that will affect his ability to think and communicate. This fundamental interest is not limited to those free of any mental illness. Rather the First Amendment protects the interest of all persons to avoid government interference

with their ability to produce and communicate their thoughts.

The intrusion sought by the government is extensive and reaches far beyond its short-term prosecutorial goals. The forced medication sought by the government could have a life-long impact on Dr. Sell's ability to think and communicate. It impacts far more than just the symptoms of his mental illness, altering the very essence of his identity. Even the court below acknowledged that antipsychotic drugs alter a person's "cognitive processes" and that the drugs "can have serious, even fatal, side effects," *U.S. v. Sell*, 282 F.3d 560, 563 n.4 (8th Cir. 2002). (quoting *Harper*, 494 U.S. at 229.) However, the court below did not seriously consider the protection of Dr. Sell's thought processes, emotions, and ability to communicate free from government control. The court below failed to discuss Dr. Sell's First Amendment interests to be free from government ordered antipsychotic drugs, or how forced medication would impact that interest. By failing to address Dr. Sell's First Amendment rights of freedom of thought, to control his own mental processes, and to communicate with his lawyer in a non-drugged induced state, the court below failed to weigh all of Dr. Sell's fundamental liberty interests against the interest of the government to bring him to trial. Thus, the decision below approving of the forced medication of Dr. Sell should be reversed for failing to weigh all of his liberty interests to bodily integrity.

B. The Forcible Medication Of The Petitioner Infringes Upon His Fifth Amendment Interests.

The court below failed to consider the nature and extent of Dr. Sell's Fifth Amendment interests to bodily

integrity as a pretrial detainee to be free from forced medication. This Court has recognized that forced medication implicates a defendant's Fifth Amendment liberty interest in being free from bodily intrusion: "The forcible injection of medication into a non-consenting person's body represents a substantial interference with that person's liberty." *Harper*, 494 U.S. at 229. Dr. Sell's liberty interest is heightened by the fact that he is a pretrial detainee who is presumed innocent and is entitled to "at least those constitutional rights that we have held are enjoyed by convicted prisoners." *Bell v. Wolfish*, 441 U.S. 520, 545 (1979). Moreover, while Dr. Sell has been found incompetent to stand trial, he has not been found incompetent to make his own medical decisions. His fundamental interest in making choices about his bodily integrity is not rendered meaningless because he is charged with a crime. In Dr. Sell's case, where the medications at issue have serious and sometimes irreversible side effects, the court below erred by failing to consider the full extent of Dr. Sell's interests and the risks posed by the drugs. *See Harper,* 494 U.S. at 229. ("While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects."); *Brandon,* 158 F.3d at 954 ("Although the various drugs might have beneficial results, the concomitant side effects might be severe and irreversible.").

The government seeks to forcibly inject Dr. Sell with powerful antipsychotic drugs that carry the potential for very harmful and long-term side effects, including the possibility of death. The court below found that one of the side effects of the antipsychotic drugs the government wants to inject into Dr. Sell is "neuroleptic malignant syndrome, which is rare but fatal." *Sell*, 282 F.3d at 569. In *Harper*, a concurring opinion notes that thirty percent of the

persons who develop neuroleptic malignant syndrome die. *Harper*, 494 U.S. at 240 (Stevens, J., concurring). The court below found that other harmful side effects included "tardive dyskinesia and/or dystonic reaction, which causes a person to have involuntary movements of various parts of the body." *Sell*, 282 F.3d at 569. In *Harper*, this Court observed that "10 to 25%" of persons taking antipsychotic medication develop tardive dyskinesia. *Harper*, 494 U.S. at 230. Yet, despite these potentially dangerous and unavoidable side effects, the court below affirmed the district court order to forcibly inject Dr. Sell with antipsychotic drugs "on the chance it will make him competent to stand trial." *Sell*, 282 F.3d. at 572 (Bye, J., dissenting). In reaching its decision, the court below did not discuss *why* the government's interest to bring Dr. Sell to trial for non-violent offenses justified violating his right to bodily integrity and the substantial risks of side effects. Rather, the court below simply denied that Dr. Sell has a constitutionally protected interest in making his own decision whether to accept or reject the administration of potentially dangerous drugs.

The court below also based its decision to approve forcible medication of Dr. Sell on very limited evidence that antipsychotic drugs are medically appropriate. There was evidence that antipsychotic drugs are not effective for persons with "delusional disorder," Dr. Sell's medical condition, and therefore not medically appropriate for Dr. Sell. *Id.* at 569-570. The government's witnesses could not say with any certainty that the antipsychotic drugs would be medically appropriate or effective in making Dr. Sell competent to stand trial. *Id.* One of the government's medical witnesses indicated that he had only treated two persons diagnosed with delusional disorder using antipsychotic drugs for the purpose of attempting to restore them

to competency, and the medication was successful on only one person. *Id.* at 569. The second government medical witness had treated four persons diagnosed with delusional disorder using antipsychotic drugs with the purpose of attempting to restore them to competency, and the medication was successful on three of them. *Id.* In considering this conflicting evidence, the court below summarily found that the government witnesses' very limited experience with only six persons, two of whom did not regain competency, was sufficient to outweigh Dr. Sell's interest in bodily integrity to be free from potentially harmful drugs. *Id.* 570. On such limited evidence, involuntary medication of Dr. Sell simply cannot be justified by the government's solely prosecutorial interests.

The court below failed to consider the less intrusive alternative of Dr. Sell remaining in custody until he becomes competent to stand trial. The dissent notes that Dr. Sell will not be set free, and instead could face civil commitment until he becomes competent to stand trial. *Id.* at 574 (Bye, J., dissenting); *see Riggins*, 504 U.S. at 145 (Kennedy, J., concurring) (stating that if the State cannot render a defendant competent without involuntary medication, then it can resort to civil commitment). Thus, the question is not so much *whether* Dr. Sell will come to trial, but *when*. The government has less restrictive tools at its disposal through the civil commitment process to address its interest as to Dr. Sell.

The court below misapplied this Court's decision in *Riggins* in evaluating Dr. Sell's Fifth Amendment interest because Dr. Sell is not a danger to himself or others. In *Riggins*, this Court stated that pretrial detainees have *at least* the same rights as prisoners, though it stated that the government may be able to show an "overriding

justification" sufficient to warrant involuntary medication at a trial or in a pretrial setting. *Riggins*, 504 U.S. at 135. Such a justification has never been found to exist as to a non-dangerous detainee charged with non-violent offenses. *Riggins* expressly considered the danger level of the prisoner, who was ultimately tried and convicted of murder and robbery, in balancing Riggins's interest against those of the government. "Taking account of the unique circumstances of penal confinement, however, we determined that due process allows a mentally ill inmate to be treated involuntarily with antipsychotic drugs *where there is a determination that 'the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.'*" *Id.* at 135, *quoting Harper*, 494 U.S. at 227 (emphasis added). None of these factors are present here. The government admittedly has no safety interest and no evidence has been presented showing that the medication is in Sell's medical interest.

Riggins does not address whether pretrial detainees awaiting trial on non-violent offenses who have been found to be non-dangerous, such as Dr. Sell, have a greater liberty interest than pretrial detainees who are dangerous and awaiting trial for serious violent offenses. Indeed, the court expressly stated it would not deal with that issue. However, another Circuit has explicitly addressed this question within the parameters of the *Riggins* test. The Sixth Circuit Court concluded that the government's interest in prosecuting a non-dangerous defendant for non-violent crimes is never sufficient to overcome the defendant's liberty interests in avoiding involuntary medication. *Brandon*, 158 F. 3d at 958.

The court below failed to consider that Dr. Sell was not dangerous nor a convicted prisoner, and it therefore

unduly expanded the *Harper* and *Riggins* holdings to include non-dangerous pretrial detainees charged with non-violent offenses. Indeed, the panel's decision below affords a non-dangerous, unconvicted pre-trial detainee fewer due process rights than convicted prisoners, who must be deemed dangerous to justify forced medication. Such a conclusion is inconsistent with the holdings of this Court and with the fundamental liberty interests at stake. *Harper* and *Riggins* involved defendants charged with violent crimes of robbery or robbery and murder. *Harper*, 494 U.S. at 217 (convicted of robbery); *Riggins*, 504 U.S. at 130 (convicted of robbery and murder). Both decisions are limited to dangerous or incarcerated defendants and the lower court's decision unjustifiably expands those holdings. Thus, the decision of the court below impermissibly infringes on Dr. Sell's Fifth Amendment interests to bodily integrity.

II. The Court Below Failed To Weigh Properly Petitioner's Liberty Interest In Bodily Integrity Against The Government's Interest In Administering Antipsychotic Medications Against His Will Solely To Attempt To Render Him Competent To Stand Trial For Non-Violent Offenses.

Under the standard of review articulated in *Riggins*, 504 U.S. 127, this Court should overturn the court medication order in Dr. Sell's case. This Court's cases establish the constitutional principles that protect liberty interests of bodily integrity and an individual's right to refuse antipsychotic drugs, though there may be limited exceptions when the government can demonstrate a compelling reason to infringe upon those rights. In order to justify the

government overriding a defendant's liberty interest to be free from forced medication, this Court held that three conditions must be met: 1) treatment with antipsychotic medication must be "medically appropriate," 2) there are no "less intrusive alternatives," *and* 3) the antipsychotic medication is "essential for the sake of . . . [the defendant's] own safety or the safety of others" or there are "other compelling" reasons to justify forced medication. *Riggins*, 504 U.S. at 135-136. This Court overturned the court medication order in *Riggins* for inadequate factual findings, including both a lack of evidence that continued administration of the antipsychotic drug was required and because there was no "finding that safety considerations or other compelling concerns outweighed Riggins' interest in freedom from unwanted antipsychotic drugs." *Id.* at 136.

Though it purported to apply the three-part test in *Riggins*, the court below in fact misapplied each part of that test. First, there has been no showing on this record that the involuntary medication the state has proposed is "medically appropriate" within the *Riggins* test, 504 U.S. at 127-28, given Dr. Sell's condition.

Second, the court below failed to consider whether there are "less intrusive alternatives" to achieve the government's objective. As the dissent below pointed out, if the government is concerned that Dr. Sell will be "set free," it can seek to civilly commit him "until he becomes competent, or voluntarily agrees to take medication." *Id.* at 574 (Bye, J., dissenting) (citing *Riggins*, 504 U.S. at 146 (Kennedy, J., concurring)). If appropriate on these facts and under state law, civil commitment is consistent with both the incapacitation and deterrence features of any potential prison sentence should Dr. Sell be convicted at trial. His confinement awaiting trial both incapacitates

him and it deters him and others from engaging in conduct that may give rise to possible criminal prosecution. The decision of the court below is silent with respect to how society's interests would be furthered by forcible injection of medications that may not even achieve the government's purpose of bringing Dr. Sell to trial in the immediate future. Dr. Sell has been confined for over four years awaiting trial for non-violent offenses that the dissenting judge below estimates under United States Sentencing Guidelines would result in thirty-three to forty-four months of incarceration *if* he were found guilty. *Sell*, 282 F.3d at 573 (Bye, J., dissenting). In failing to address the possibility of civil commitment, the court below failed to consider less intrusive alternatives to forced injections of antipsychotic drugs that, at best, *may possibly* make Dr. Sell competent to stand trial.

Third, the court below failed to find that the antipsychotic drugs are "essential" for Dr. Sell's own safety or the safety of others, and it did not find other "compelling concerns" that outweigh Dr. Sell's interests to be free from forced medication. *See Riggins*, 504 U.S. at 135-136. The court below affirmed the trial court's decision that Dr. Sell does not pose a danger to himself or others. *Sell*, 282 F.3d at 565 ("the evidence does not support a finding that Sell posed a danger to himself or others at the Medical Center."). In addition, the court below did not offer any analysis to support its conclusion that the government's interest in bringing Dr. Sell to trial was "essential" or "paramount," let alone compelling. *Id*. at 568.

Riggins held that the government must prove "safety considerations or other compelling concerns" to outweigh "the defendant's liberty interest in freedom from unwanted antipsychotic drugs." 504 U.S. at 136-137. Rather than

adhering to this requirement, the majority below "perfunctorily concludes that the government's interest in prosecuting" Dr. Sell for non-violent crimes outweighs his "significant liberty interest in refusing antipsychotic medication." *Sell*, 282 F.3d at 572 (Bye, J., dissenting). The dissent below contends that the majority deemed the sixty-two counts of fraud and single count of money laundering facing Dr. Sell as "serious" because of their sheer number. *Id*. at 573 (Bye, J., dissenting).

The dissent below described the majority's lack of analysis into the government's interest, and the dissent demonstrates that the government did not meet its burden of proving a compelling interest to use antipsychotic drugs with the hope of bringing to trial a person, Dr. Sell, charged with non-violent crimes. *Id*. at 572-574 (J. Bye, dissenting). The dissent makes clear that, based on the lack of severity of the charges against Dr. Sell and the substantial liberty interests at stake, the government's interest in prosecuting Dr. Sell's alleged economic crimes is not compelling. *Id*.

In upholding the government's interest in bringing Dr. Sell to trial even if it means overriding his liberty interests to bodily integrity, the court below relied, in part, on *U.S. v. Weston*, 255 F.3d 873, 880 (D.C. Cir. 2001). But, unlike the decision of the court below, the *Weston* court did weigh at length the government's interest in bringing a person charged with violent crimes to trial, finding that the grave nature of Weston's alleged crimes (murder) rendered the government's interest "essential." *Weston*, 225 F.3d at 881. The *Weston* court acknowledged that in spite of cases describing the government's general interest in adjudicating crimes as significant, the government's interest is not absolute: "We need not decide under what circumstances

trying and punishing offenders is not 'essential.' The government's interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business." *Id.* at 880. Thus, *Weston* deals with the narrow issue of the government's interest in adjudicating violent crimes that carry substantial punishments and should not be held to stand for the principle that the governmental interest in bringing *all* individuals to trial is compelling even when the charges against the individual involve less serious non-violent offenses. Indeed, other courts have doubted that the government's interest in forcibly medicating a defendant in order to prosecute him can ever be compelling for less serious offenses. *See Brandon*, 158 F.2d at 961 (interest in prosecuting defendant for sending threatening mail not sufficiently compelling to justify medication); *Greaves*, 744 F.2d at 1395 (questioning whether government's prosecutorial interests could ever be compelling enough when balanced against a defendant's right to be free from involuntary medication).

While the court below seemed to acknowledge a duty to analyze the nature of the government's interest in bringing persons charged with non-violent crimes to trial, it failed to satisfy this requirement. Rather, the majority concluded, without any analysis, that the "charges of fraud and the single charge of money-laundering are serious." *Sell*, 282 F.3d at 568. The majority opinion does acknowledge that "[n]ot all charges ... are sufficient to justify forcible medication of a defendant; rather the charges must be serious." *Id.* at 568 (citing *Brandon*, 158 F.3d at 961). Yet, the court below failed to explain *why* or *how* the charges facing Dr. Sell are serious, which is essential to

analyzing whether the government's interest in prosecuting these charges would be considered compelling.

Although the court below cited *Brandon*, 158 F.3d at 961, for the proposition that charges must be serious to justify forcible medication of a defendant, the majority opinion did not consider that Dr. Sell was only facing a likely sentence of thirty-three to forty-one months if convicted, which is much closer to the maximum potential sentence of five years' imprisonment in the *Brandon* case rather than life imprisonment or the death penalty in the *Weston* case. *Sell*, 282 F.3d at 573 (Bye, J., dissenting). In *Brandon*, the court held that "the risk of error and possible harm involved in deciding whether to forcibly medicate an incompetent, non-dangerous pretrial detainee are likewise so substantial as to require the government to prove its case by clear and convincing evidence." *Brandon*, 158 F.3d at 961. Rather than requiring "clear and convincing evidence" of the government's interest in bringing Dr. Sell to trial for non-violent offenses, the majority below simply assumed such an interest existed.

The government's own witnesses cannot predict with any certainty that even with psychotropic drugs Dr. Sell will become competent to stand trial, and there is no dispute that the available drugs are potentially harmful. *Sell*, 282 F.3d 570-571. Dr. Sell has not been proven guilty of any crime, he faces trial for non-violent offenses carrying likely potential incarceration for less time than he has already been confined, he is not a threat to himself or others, and the government has a less restrictive option of seeking to keep Dr. Sell institutionalized until and unless he becomes competent to stand trial. The government has

not met the test articulated in *Riggins*, and the involuntary medication order should be overturned.

CONCLUSION

For the foregoing reasons, this Court should reverse the judgment of the United States Court of Appeals for the Eighth Circuit and declare that the government may not involuntarily medicate the Petitioner, Dr. Sell, for the purpose of rendering him competent to stand trial.

Respectfully submitted,

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IN THE
SUPREME COURT OF THE UNITED STATES

CHARLES THOMAS SELL,
Petitioner,

v.

UNITED STATES,
Respondent.

On Writ of Certiorari to the United States
Court of Appeals for the Eighth Circuit

BRIEF *AMICUS CURIAE* OF THE RUTHERFORD INSTITUTE IN SUPPORT OF PETITIONER

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STATEMENT OF INTEREST OF AMICUS CURIAE AND INTRODUCTION[1]

The Rutherford Institute is an international, non-profit civil liberties organization with offices in Charlottesville, Virginia and internationally. The Institute, founded in 1982 by its President, John W. Whitehead, educates and litigates on behalf of constitutional and civil liberties. Attorneys affiliated with the Institute have filed briefs in the United States Supreme Court on behalf of the rights of the accused in numerous significant criminal justice cases, including *Illinois v. Wardlow*, 528 U.S. 119 (2000), *Apprendi v. New Jersey*, 530 U.S. 466 (2000) and *Indianapolis v. Edmond*, 531 U.S. 32 (2000). The Institute has published educational materials and taught continuing legal education classes in this area as well.

The Rutherford Institute is participating in *Sell v. United States* as an *amicus* of the Court because it regards this appeal as a potentially groundbreaking case in the areas of bodily integrity and freedom of thought. Certainly, where mentally disabled persons in the government's care pose an immediate threat to themselves or others, the government has a compelling interest in providing reasonable treatment to prevent such harm. Furthermore, the government has an important interest in bringing those charged with criminal activity to trial. However, the government must not be

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[1] *Amicus curiae* The Rutherford Institute files this brief by consent of counsel for both parties. Copies of the letters of consent are on file with the Clerk of the Court. Counsel for The Rutherford Institute authored this brief in its entirety. No person or entity, other than The Institute, its supporters, or its counsel, made a monetary contribution to the preparation or submission of this brief.

permitted to resort to the forcible injection of nondangerous individuals with dangerous mind-altering medications in an effort to bring individuals to trial for nonviolent crimes.

SUMMARY OF THE ARGUMENT

The forcible injection of antipsychotic medication into one's body is a substantial invasion of an individual's rights to maintain one's bodily integrity and to control one's thoughts. Given these invasions of an individual's rights as well as the danger associated with these medications, the government should not be permitted to forcibly medicate individuals unless its action is the least restrictive means available to meet a compelling government interest. The government's interest in increasing the likelihood that an individual may be brought to a fair and impartial trial is not sufficiently compelling to enable the government to forcibly inject dangerous and mind-altering antipsychotic drugs into a non-dangerous pretrial detainee still cloaked with the presumption of innocence. This is particularly true where, as in this case, the alleged crime for which the government seeks to bring the pretrial detainee to trial is a nonviolent offense.

ARGUMENT

I. STRICT SCRUTINY SHOULD APPLY TO THE FORCIBLE ADMINISTRATION OF ANTIPSYCHOTIC DRUGS TO PRETRIAL DETAINEES.

Government actions which implicate fundamental rights must satisfy strict scrutiny review, whereby such actions must be justified by a compelling state interest and the absence of lesser intrusive alternatives to achieve the interest. *Griswold v. Connecticut*, 381

U.S. 479, 497 (1965). The pretrial detainee, no less than any other person, possesses fundamental constitutional rights which should not be infringed unless the action is narrowly tailored to satisfy a compelling government interest. The state's mere allegations that a citizen has committed non-violent crimes should not suffice to override these fundamental rights.

A. FORCIBLE ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION TO A PRETRIAL DETAINEE IMPLICATES THE DETAINEE'S FUNDAMENTAL FIFTH AMENDMENT RIGHT TO REFUSE MEDICAL TREATMENT.

1. The Due Process Clause of the Fifth Amendment Encompasses the Right to Refuse Antipsychotic Medication.

The right to preserve one's bodily integrity by refusing unwanted medical treatment is a paramount right in the hierarchy of constitutional values. As the Court has stated:

> No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 269 (1990), *quoting Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891). *See also Schmerber v. California*, 384 U.S. 757, 771 (1966) ("The integrity of an individual's person is a cherished value of our society.") The common law recognized the importance of the right of bodily integrity by making nonconsensual

medical procedures actionable in tort as battery. *See Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-30 (N.Y. 1914) (Cardozo), *overruled on other grounds by Bing v. Thunig*, 2 N.Y.2d 656 (1957). Numerous federal circuit and district courts have also recognized that the due process clauses of the Fifth and Fourteenth amendments protect the right to avoid unwanted psychiatric treatment. *See, e.g., United States v. Brandon*, 158 F.3d 947, 953 (6th Cir. 1998); *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985).

Moreover, in two cases arising from the correctional context, this Court has recognized that "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." *Washington v. Harper*, 494 U.S. 210, 229 (1990), quoted in *Riggins v. Nevada*, 504 U.S. 127, 133-34 (1992). In those cases, involving involuntary medication by *state* officials, the Court found the liberty interest in avoiding injections of anti-psychotic drugs in the Due Process Clause of the Fourteenth Amendment. Where, as in this case, the *federal* government seeks to forcibly inject a pre-trial detainee with anti-psychotic medication, the detainee's liberty interest in his bodily integrity is rooted in the Due Process Clause of the Fifth Amendment. *Brandon*, 158 F.3d at 953.

2. The Forced Injection of Antipsychotic Drugs is a Substantial Invasion of One's Bodily Integrity.

The invasion of one's bodily integrity imposed by forced antipsychotic medication is substantial. This Court has previously observed that "the drugs can have serious, even fatal, side effects." *Harper*, 494 U.S. at 229. Indeed, the government's medical expert

in the instant case testified that .01% of persons treated with antipsychotic drugs will develop neuroleptic malignant syndrome, a "rare but fatal" reaction. *Sell*, 282 F.3d 560, 569 and n. 13 (testimony that one in ten thousand chance existed). Other studies have indicated that antipsychotic drugs may also cause a variety of blood disorders called dyscrasias. One of these blood disorders, agranulocytosis, causes a decrease in white blood cells, rendering the patient susceptible to life-threatening infections. Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283, 298-99 (1992). Thus, by forcibly injecting antipsychotic drugs into non-dangerous pretrial detainees, the government exposes those persons to potentially fatal consequences.

Antipsychotic drugs may also result in many other debilitating, albeit nonfatal, side effects. This Court has previously recognized that antipsychotic drugs can cause tardive dyskinesia, "a neurological disorder, irreversible in some cases, that is characterized by involuntary, uncontrollable movements of various muscles, especially around the face." *Harper*, 494 U.S. at 229-30, citing *Mills v. Rogers*, 457 U.S. 291, 293, n.1 (1982). In *Harper*, this Court recognized that between 10 and 25% of those treated with antipsychotic drugs will develop tardive dyskinesia. 494 U.S. at 229-30. Other side effects of antipsychotic drugs which this Court has recognized include acute dystonia, "a severe involuntary spasm of the upper body, tongue, throat, or eyes," and akathisia, "motor restlesness, often characterized by an inability to sit still." *Harper*, 494 U.S. at 229-30. *See also Mills*, 457 U.S. at 293, n.1. Some evidence also suggests that "akathisia, in the extreme case, can drive people to suicide or to homicide." Cichon, 53 LA. L. REV. at 302, *quoting* Theodore Van Putten & Stephen R. Marder, *Behavioral Toxicity of Antipsychotic Drugs*, 48 J. CLINICAL

PSYCHIATRY 13, 14 (1987). Some studies have indicated that over 60% of those who receive antipsychotic drugs will suffer from some symptoms of akathisia, with over 20% suffering from severe akathisia. Cichon, 53 LA. L. REV. at 302.

Medical studies have revealed a long list of other side effects which may result from antipsychotic medications. These include dry mouth, constipation, intestinal paralysis (paralytic ileus), blurred vision or blindness, impotence, reversed ejaculation into the bladder, priapism (sustained and painful erections that may require surgery), infertility, spontaneous lactation, skin disorders ranging from rashes to irreversible discolorations, jaundice, liver dysfunction, and cardiovascular irregularities. Cichon, 53 LA. L. REV. at 297-99. Antipsychotic drugs may also cause varying degrees of parkinsonism, a disorder with effects similar to Parkinson's disease. The symptoms of parkinsonism include "'a mask-like face,' drooling, muscle stiffness and rigidity, shuffling gait [and] tremors .... In less severe cases, the patient may seem apathetic and bored with a 'zombie-like' appearance." Brian Shagan, *Washington v. Harper: Forced Medication and Substantive Due Process*, 25 CONN. L. REV. 265, 268 (1992). See also *Mills*, 457 U.S. at 293, n.1.

The dangers inherent in the administration of antipsychotic drugs highlights the importance of the individual's interest in avoiding forced treatment. These medications can produce debilitating, life-altering and even fatal side-effects. Thus, they bear no resemblance to much less intrusive medical interventions which the Court has determined implicate only a minimal liberty interest. *See Schmerber*, 384 U.S. at 771 (pin prick of finger for a blood test). Indeed, the risks and extent of harm inherent in the administration of antipsychotic drugs to pretrial detainees are at least as serious as

those which the Court has previously held to outweigh the government's interests. *See Winston v. Lee*, 470 U.S. 753, 755-56 (1985) (surgical removal of a bullet); *Rochin v. California*, 342 U.S. 165, 172 (1952) (forced insertion of a stomach pump). The use of chemical agents to alter one's mind and to potentially affect one's muscular and other bodily functions is at least as invasive as the mechanical invasion of surgery. The pre-trial detainee's interest in avoiding the administration of these dangerous and potentially life-threatening drugs should not be infringed unless the government's action is the least restrictive means by which it may accomplish a compelling interest.

B. FORCIBLE ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION TO A PRETRIAL DETAINEE IMPLICATES THE DETAINEE'S FUNDAMENTAL RIGHT TO FREEDOM OF THOUGHT.

As this Court noted in *Riggins*, 504 U.S. at 134, the invasion of one's bodily integrity posed by the forcible injection of antipsychotic medication is particularly severe because the medication affects not only the body, but the mind as well. *See also Harper*, 494 U.S. at 229. The government should not be permitted to forcibly alter a pretrial detainee's mental functions by the use of antipsychotic medication unless its action is the least restrictive means by which it may accomplish a compelling interest.

1. The First Amendment Protects Freedom of Thought.

The First Amendment protects persons from government interference with their thoughts at least as stringently as it protects spoken or written words. This Court has held that although the First

Amendment directly refers only to "freedom of speech," it also protects the "freedom of thought" which is a necessary predicate to the freedom of speech. *Texas v. Johnson*, 491 U.S. 397, 404 (1989) ("The First Amendment['s] protection does not end at the spoken or written word."); *Abood v. Detroit Bd. of Ed.*, 431 U.S. 209 (1977) ("At the heart of the First Amendment is the notion that an individual should be free to believe as he will, and that in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State"); *Wooley v. Maynard*, 430 U.S. 705 (1977) (holding that a New Hampshire statute mandating the display of license plates bearing the state motto "Live Free or Die" violated "the right of freedom of thought protected by the First Amendment"). In *Palko v. Connecticut*, 302 U.S. 319, 326-27 (1937), this Court recognized that "freedom of thought ... is the matrix, the indispensable condition, of nearly every other form of freedom."

As this Court has observed, "[o]ur whole constitutional heritage rebels at the thought of giving government the power to control men's minds." *Stanley v. Georgia*, 394 U.S. 557, 565-66 (1969). In his preamble to Virginia's Statute for Religious Freedom," Thomas Jefferson wrote:

> ... Almighty God hath created the mind free, and manifested his supreme will that free it shall remain by making it altogether insusceptible of restraint; that all attempts to influence it by temporal punishments, or burdens, or by civil incapacitations ... are a departure from the plan of the holy author of our religion...

Thomas Jefferson, *Virginia Statute for Religious Freedom* (1785). Indeed, the First Amendment's protection of the freedom

of speech would be worthless if the government were permitted to control the thoughts that give rise to that speech.

2. Antipsychotic Drugs Interfere With an Individual's Mental Processes.

In *Riggins*, 504 U.S. at 134, quoting *Harper*, 494 U.S. at 229, this Court held that the interference with a person's liberty interest under the Due Process Clause was "particularly severe" because the injections do not merely interfere with the detainee's bodily integrity, but their express purpose is "'to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes.'" In *Mills*, this Court also recognized that the very purpose of antipsychotic drugs was to alter one's mind. 457 U.S. at 293, n.1. However supposedly beneficial the effects of antipsychotic medications, it is undeniable that their intended effect is to alter Dr. Sell's mental processes.

Aside from the arguably beneficial effects on an individual's otherwise "abnormal" mental processes, antipsychotic drugs also affect other "normal" mental processes. The common side effects of the drugs include sedation, a sense of apathy and impairment of one's concentration and ability to speak. Cichon, 53 LA. L. REV. at 301; Winick, Bruce J., *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1, 70-71 (1989). The Tenth Circuit has observed that "antipsychotic drugs have the capacity to severely and even permanently effect an individual's ability to think and communicate." *Bee v. Greaves*, 744 F.2d at 1394. The Ninth Circuit has also recognized that antipsychotic medication may cause "impermissible tinkering with the mental processes." *Mackey v. Procunier*, 477 F.2d 877, 878 (9th Cir. 1973). Both the ostensibly beneficial and

the detrimental effects of antipsychotic drugs thereby alter the patient's thought processes and ability to think and reason.

3. That the Use of Antipsychotic Medication is Intended to Restore "Normalcy" to the Patient Should not Diminish Scrutiny of the Government's Actions.

The fact that antipsychotic drugs are intended to benefit a patient by restoring "normal" thought processes should not reduce the level of scrutiny where the government seeks to forcibly administer these agents. As Justice Brandeis warned in *Olmstead v. U.S.*, 277 U.S. 438, 479 (1928) (Brandeis, J., Concurring):

> Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.

More recently, several members of this Court have affirmed that judicial scrutiny of government's intrusion on individuals' rights is not lessened merely because the government asserts benevolent motives. In *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 226 (1995), this Court held that strict scrutiny applies to racial classifications by the government even where the racial classification is "benign." Justice Thomas dismissed the notion that any lesser standard of review should be applied to actions which the government claimed were well-meaning:

> That these programs have been motivated, in part, by good intentions cannot provide refuge from the principle that

> under our Constitution, the government may not make distinctions on the basis of race.

Adarand Constructors, 515 U.S. at 240 (Thomas, J., concurring). Several years earlier, Justice O'Connor, joined by Chief Justice Rehnquist and Justices Scalia and Kennedy, criticized the Court's lesser standard of review for "benign racial classifications," stating, "the Court's emphasis on 'benign racial classifications' suggests confidence in its ability to distinguish good from harmful uses of racial criteria. History should teach greater humility." *Metro Broadcasting, Inc. v. FCC*, 497 U.S. 547, 609 (1990) (O'Connor, J., dissenting). *See also Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 723 (1982) (That a statute discriminated against males rather than females "does not exempt it from scrutiny or reduce the standard of review.")

Moreover, lowering the bar for the government to forcibly administer mind-altering drugs to an individual where it does so to "restore normalcy" would require courts to make the historically elusive and dubious distinction between normal and abnormal thoughts. What constitutes normal mental processes is necessarily subjective and changes over time. No objective definition of normalcy can be identified by which courts can differentiate between well-intended and ill-intended forced injections of individuals with antipsychotic medications. For example, as recently as the late 1980's Soviet psychiatrists used antipsychotic medication to "treat" individuals for "delusions of reformism" and "anti-Soviet thoughts." Richard J. Bonnie & Svetlana V. Polubinskaya, *Unraveling Soviet Psychiatry*, 10 J. CONTEMP. LEGAL ISSUES 279, 282-83 (1999). *Cf. Buck v. Bell*, 274 U.S. 200, 207 (1927) with *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (criticizing rationale of *Buck*). In view of the jurisprudential

lessons of history in this area, the Court should avoid making itself the final arbiter for what are normal or abnormal thoughts. Such would come perilously close to the government prescribed orthodoxy of thought that this Court refuted in *West Virginia v. Barnette*, 319 U.S. 624, 642 (1943).

II. Pretrial Detainees' Fundamental Rights Are Not Outweighed by the Government's Interest in Increasing the Possibility that He Will Become Competent to Stand Trial for Nonviolent Crimes.

That the government has an interest, even an important one, in bringing an individual suspected of criminal activity to trial is undeniable. *See, Illinois v. Allen*, 397 U.S. 337, 347 (1970) (Brennan, J., concurring) ("Constitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and a prerequisite to social justice and peace.") The question in this case, however, is whether the government's interest is so compelling that it overrides the fundamental rights of a non-dangerous pretrial detainee, requiring him to have his bodily integrity violated, risking serious side effects and even death, and allowing his mind to be chemically altered so that the government can attempt to render him sufficiently competent to stand trial on nonviolent crimes. To make this determination, the Court must first define the precise governmental interest at stake.

A. The Government's Interest is in Increasing the Likelihood that a Defendant May be Brought to a *Fair* Trial.

1. The State's Interest, like that of the Criminal Defendant, is in a Fair Trial.

The interest of the state is not in merely subjecting a person to the machination of the court system and achieving a verdict. The state itself, no less than the criminal Defendant, has an interest in a fair and impartial trial. In *J.E.B. v. Alabama*, 511 U.S. 127, 137 (1995) (The "state's interest in *every* trial is to see that the proceedings are carried out in a fair, impartial, and nondiscriminatory manner." (emphasis in *J.E.B.*) The Sixth Amendment right to a fair trial must not be viewed as a protection for the Defendant and a countervailing obstacle for the state. If it were, then the government could argue that its compelling interest in bringing criminal Defendants to trial justified its trying even some incompetents. *Compare Pate v. Robinson*, 383 U.S. 375 (1966) (holding that the Constitution prohibits the government from bringing an incompetent Defendant to trial). But the Sixth Amendment is not merely a protection for the individual, it expresses the interest of the state as well in maintaining a fair and impartial criminal justice system. "Society wins not only when the guilty are convicted but when criminal trials are fair; our system of the administration of justice suffers when any accused is treated unfairly." *Brady v. Maryland*, 373 U.S. 83, 87 (1963). The Sixth Amendment helps to ensure that only the proper person is convicted. The interests of neither the state nor the public are advanced if the wrong person is convicted of committing a crime. Similarly, the Sixth Amendment right to a fair trial helps to ensure public confidence in the criminal justice system. A system in which the state's interest is in merely achieving guilty verdicts while the criminal Defendant's interest alone is in fairness and impartiality would quickly lose public confidence. Thus, the state, no less than the criminal Defendant, has an interest in a fair and impartial trial.

There is a substantial possibility that even if Dr. Sell is restored

to a level of competency technically sufficient to allow the government to constitutionally bring him to trial, the resulting trial would nonetheless be less than the fair and impartial trial that is in the government's interest. *See, J.E.B.*, 511 U.S. 127; *Riggins*, 504 U.S. at 142-43 (Kennedy, J., concurring). As Justice Kennedy observed in *Riggins*, 504 U.S. at 142-43:

> It is a fundamental assumption of the adversary system that the trier of fact observes the accused throughout the trial ... At all stages of the proceedings, the defendant's behavior, manner, facial expressions, and emotional responses, or their absence, combine to make an overall impression on the trier of fact .... The side effects of antipsychotic drugs may alter demeanor in a way that will prejudice all facets of the defense. Serious due process concerns are implicated when the State manipulates the evidence this way.

Moreover, "[t]he side effects of antipsychotic drugs can hamper the attorney-client relation, preventing effective communication and rendering the defendant less able or willing to take part in his defense. The State interferes with this relation when it administers a drug to dull cognition." *Riggins*, 504 U.S. at 143-44 (Kennedy, J., concurring) at 144. If the antipsychotic medications forcibly administered to a Defendant cause him to be unable to express remorse for his actions or to control his facial expressions at trial, or to fully communicate with his attorneys, the fairness of the trial may rightly be doubted. *Id.* at 144.

Because these potential effects on the pretrial detainee call into question the fairness of the trial, the government's interest in a fair and impartial trial is compromised. More importantly, because the government's interest is in administering a fair and impartial trial, the

government should be required to bear the burden of demonstrating that its forcible administration of antipsychotic drugs on a pretrial detainee for the purpose of restoring his competency will not cause the types of side effects discussed above that could result in an unfair and prejudiced trial. If the government cannot make such a showing, then it has failed to assert a compelling government interest that may override the pretrial detainee's fundamental rights.

2. The Government's Interest Should be Discounted by the Possibility that the Treatments Will Not Restore Sell's Competency.

The substantial possibility that the forcible administration of antipsychotic drugs will not restore Sell's competency diminishes the value of the state's interest. This Court has recognized that the likelihood that the government will be able to accomplish its objective is relevant to the balancing of the interests of the government and the individual where the government seeks to violate an individual's bodily integrity. *See Schmerber*, 384 U.S. at 771 (citing the effectiveness of blood sample testing for determining whether an individual is intoxicated). This requirement ensures that however compelling the government's interest might be in theory, it should not be permitted to burden an individual's rights, or in this case, to subject them to the risk of serious and even deadly side effects, if it has little realistic hope of satisfying that interest. By the same token, where the likelihood of the government meeting its interest is less than certain, that uncertainty must be considered when determining whether the individual must be placed at risk in order for the government to attempt to achieve its interest.

The Eighth Circuit recognized that "we cannot say with 100% certainty whether Sell will regain competency with this treatment."

282 F.3d at 570. Indeed, the government's two medical experts testified that they had a 50 – 75% rate of success in using antipsychotic medication to restore competency to persons, like Dr. Sell, with delusional disorders.[2] *Id.* Thus, if the government is permitted to forcibly administer the antipsychotic medications to Dr. Sell, there is a 25 - 50% possibility that the medications would not satisfy the government's interest in restoring his competency to stand trial. As Judge Bye noted in his dissent in this case, the government is seeking to forcibly medicate Dr. Sell "*on the chance* it will make him competent to stand trial." 282 F.3d at 572 (Bye, dissenting) (emphasis added). A substantial possibility exists, however, that should the government forcibly medicate Dr. Sell, he

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[2] Furthermore, Dr. Wolfson testified that he had not been successful in restoring competency to patients with the drug Olanzapine. Nevertheless, this is one of the two drugs that he suggested as treatment for Dr. Sell.

Dr. Sell has been diagnosed with the persecutory subtype of delusional disorder. The Eighth Circuit described his diagnosis as follows:

> Delusional disorder is characterized by the presence of one or more nonbizarre delusions that persist for at least one month. The delusions are generally plausible ideas that can conceivably occur in real life. The persecutory subtype of delusional disorder is characterized by a person's belief that he is being conspired against, cheated, spied on, followed, *poisoned or drugged*, maliciously maligned, harassed, or obstructed in the pursuit of long term goals.

282 F.3d at 563, n.3 (emphasis supplied; citations omitted.) It is a supreme irony that it is in order to relieve Dr. Sell of such delusions that the government proposes to forcibly inject him with antipsychotic drugs.

would be placed at risk of the dangerous, potentially life-altering and even deadly side-effects of the medications as well as having his mental state chemically altered, all for naught. The government should not be allowed to force Dr. Sell to bear the burden of these risks.

B. The Weight of the Government's Interest in Bringing the Defendant to Trial Should Also Depend on the Seriousness of the Crime Charged.

The government's interest in increasing by 50 – 75% the likelihood that a pretrial detainee might be made sufficiently competent to allow a fair trial to be conducted is not so compelling that it should outweigh the pretrial detainee's fundamental rights to bodily integrity and to control his own thought processes. The Court's *amicus* urges the Court to hold simply that nondangerous pretrial detainees may not be forcibly medicated with antipsychotic drugs for the sole purpose of rendering them competent to stand trial. However, even if the government's interest in trying an individual is sufficient to permit the state to forcibly medicate an individual in very serious cases, the government's interest is insufficient in less serious cases like the one at bar.

Several circuit courts, including the Eighth Circuit in the instant case, have held that the seriousness of the crime charged is important to determining whether the government may forcibly medicate an individual with antipsychotic drugs in order to attempt to render the detainee competent to stand trial. *See Sell*, 282 F.3d at 568 (holding that "in view of the seriousness of the [fraud] charges" against Sell, the government's interest is paramount); *United States v. Weston*, 255 F.3d 873, 881 (D.C. Cir. 2001)

("the government's interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business"); *Brandon*, 158 F.3d at 961 (6th Cir.) ("We find it difficult to imagine … that the government's interest in prosecuting the charge of sending a threatening letter through the mail could be considered a compelling justification to forcibly medicate Brandon.").

The government seeks to forcibly medicate Sell in order to try him for making "false representations in connection with the payment of health care services," 18 U.S.C. § 1035 (a)(2) and money laundering, 18 U.S.C. § 1957(a). These are not violent crimes. 282 F.3d at 573 (Bye, dissenting). Furthermore, should Dr. Sell be convicted of these crimes, the United States Sentencing Guidelines, would suggest that Dr. Sell receive roughly 33 to 41 months in prison. *Id*. That period is longer than the approximately four years Dr. Sell has been detained pending trial. Even assuming that the government may forcibly administer antipsychotic medication to some non-dangerous pretrial detainees for the sole purpose of making them competent to stand trial, the government's interest in prosecuting Dr. Sell for these nonviolent white collar crimes is insufficient to justify the offenses to his liberty and threats to his safety posed by these drugs.

CONCLUSION

Two of our most cherished and fundamental rights are at stake in this case: the right to maintain the integrity of one's own body and the right to control one's own mind. While, like other constitutional rights, these rights are not absolute, they should nevertheless be afforded the strongest protection that this Court can offer and

should only be infringed in the narrowest circumstances. Conversely, the dangerous and intrusive nature of forcible treatment with antipsychotic medication militates against such treatment except in rare circumstances. The government's interest in attempting to bring Dr. Sell to trial for his nonviolent victimless crimes, albeit strong, is not the type of compelling justification that should suffice to override these basic rights.

The Court's *amicus* respectfully submits that for the reasons set forth herein, the judgment of the Court of Appeals should be reversed.

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Supreme Court of the United States

Dr. Charles Thomas Sell, D.D.S.
Petitioner,

v.

United States of America,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF *AMICUS CURIAE* OF THE CENTER FOR COGNITIVE LIBERTY & ETHICS IN SUPPORT OF THE PETITION

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I.
INTEREST OF AMICUS CURIAE

With the written consent of the parties reflected in letters lodged with the Clerk, undersigned counsel for the Center for Cognitive Liberty & Ethics (CCLE), submits this brief as *amicus curiae* in support of petitioner pursuant to Rule 37 of the Rules of Court.[1]

The CCLE is a nonprofit education, law, and policy center working in the public interest to foster cognitive liberty—the right of each individual to think independently, to use the full spectrum of his or her mind, and to have autonomy over his or her own brain chemistry. The CCLE encourages social policies that respect and protect the full potential and dignity of the human intellect. The CCLE was an *amicus curiae* party to this case, in support of petitioner Dr. Sell at the petition stage, and before the Eighth Circuit when Petition for Rehearing/Rehearing en banc was filed in this case.

As an organization charged with defending freedom of thought, the CCLE has a vital interest in this case because the forcible injection of a citizen with a mind-altering drug directly infringes on cognitive liberty and mental autonomy.

The CCLE is deeply concerned that the decision below seriously compromises the core of the freedoms guaranteed by the First Amendment and, if permitted to stand, will undermine the fundamental right of all citizens to have autonomy over their own minds and mental processes.

In particular, the CCLE seeks to assist the Court by demonstrating that the right at stake in this case is a fundamental First Amendment right; the infringement of

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[1] No counsel for a party authored this brief in whole or part, and no person or entity other than the *amicus curiae,* its members or its counsel, made a monetary contribution to the preparation and submission of this brief.

which must withstand strict scrutiny. The CCLE seeks to show that more is at issue in this case than what courts have commonly termed "bodily integrity." At stake is a fundamental right: the right to freedom of thought.

SUMMARY OF ARGUMENT

The CCLE submits that the court of appeals mischaracterized the fundamental right at issue in this case, and as a result, erred by applying an inappropriately low standard of review.

The fundamental right to control one's own intellect and mental processes is protected by the First Amendment, and is eviscerated if courts permit the government to forcibly drug citizens. If government agents, with the concurrence of the courts, can constitutionally order the forcible manipulation of Dr. Sell's mind in order that he may stand trial, then any accused defendant, who poses no danger to self or others, is also at jeopardy of losing his or her First Amendment right to freedom of thought. This is particularly true in light of ongoing pharmacological and technological developments, which provide unprecedented tools for forcibly altering the inner workings of the mind.

To clarify, the CCLE does not propose that the state cannot regulate the *behavior* of individuals, including the acts of individuals who are incoherent or who spit on or otherwise assault judges. We maintain that the state cannot, consistent with the First Amendment of the Constitution, forcibly manipulate the *thought processes* of individuals who do not pose a clear and present danger to others. The government may, of course, use words and other expression to advocate and persuade with the intent to alter thoughts, but the First Amendment must be read to strictly forbid the government from directly and forcibly manipulating a person's brain with the intent of changing what, or how, the person thinks.

ARGUMENT

I.

FORCIBLY ADMINISTERING MIND-ALTERING DRUGS TO A NONDANGEROUS PRETRIAL DETAINEE, SOLELY TO RENDER HIM COMPETENT TO STAND TRIAL FOR NONVIOLENT OFFENSES, IS UNCONSTITUTIONAL

In a 2-1 ruling issued on March 7, 2002, the United States Court of Appeals for the Eighth Circuit upheld a District Court order allowing the government to forcibly medicate Dr. Charles Thomas Sell with antipsychotic drugs for the sole purpose of making him competent to stand trial for a nonviolent crime. While the Eighth Circuit acknowledged that Dr. Sell has a "significant liberty interest in refusing anti-psychotic medication" *United States v. Sell*, 282 F.3d 560, 568 (2002), the court grossly undervalued the individual interest at stake in this case. The right to freedom of thought is far more than "significant;" it is situated at the very core of what it means to be a free person in a civilized society, and is a fundamental right protected by the First Amendment.

A. The First Amendment Guarantees Freedom of Thought

The First Amendment, which Professor Tribe terms "the Constitution's most majestic guarantee,"[2] provides:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances. U.S. CONST. AMEND. I.

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[2] Laurence Tribe, AMERICAN CONSTITUTIONAL LAW, § 12-1, 785 (2nd ed. 1988).

While "[t]he First Amendment literally forbids the abridgment only of 'speech,'" this Court has "long recognized that its protection does not end at the spoken or written word." *Texas v. Johnson,* 491 U.S. 397, 404 (1989); *See also Globe Newspaper Co. v. Superior Court*, 457 U.S. 596, 604 (1982) ("[W]e have long eschewed any 'narrow, literal conception' of the [First] Amendment's terms, ...for the Framers were concerned with broad principles....").

This Court has repeatedly observed that there are derivative and corollary rights that are essential to effectuate the purposes of the First Amendment, or which are inherent in the rights expressly enumerated in the Amendment. For example, in *Lamont v. Postmaster Gen.*, 381 U.S. 301, 308 (1965), Justice Brennan, in his concurring opinion explained:

> It is true that the First Amendment contains no specific guarantee of access to publications. However, the protection of the Bill of Rights goes beyond the specific guarantees to protect from congressional abridgement those equally fundamental personal rights necessary to make the express guarantees fully meaningful.

Likewise, in *Globe* this Court observed that "[t]he First Amendment is...broad enough to encompass those rights that, while not unambiguously enumerated in the very terms of the Amendment, are nonetheless necessary to the enjoyment of other First Amendment rights." *Globe,* 457 U.S. at 604. Thus, in 1982, this Court recognized a "right to receive information and ideas," locating the right as "an inherent corollary of the right of free speech and press" guaranteed by the First Amendment. *Board of Educ. v. Pico*, 457 U.S. 853, 867 (1982) (plurality opinion).

Freedom of thought, while not expressly guaranteed by the First Amendment, is one of those fundamental rights necessary to make the express guarantees meaningful. As Justice Benjamin Cardozo extolled, "freedom of thought...is the matrix, the indispensable condition, of nearly every other form of freedom. With rare aberrations a pervasive

recognition of that truth can be traced in our history, political and legal." *Palko v. Connecticut,* 302 U.S. 319, 326-27 (1937).

As this Court noted as recently as 2002, "[t]he right to think is the beginning of freedom, and speech must be protected from the government because speech is the beginning of thought." *Ashcroft v. Free Speech Coalition* 533 U.S. 234 (2002). "The guarantee of free expression," notes Professor Tribe, "is inextricably linked to the protection and preservation of open and unfettered mental activity... ." L. Tribe, *supra,* § 15-7, at 1322 (2nd ed. 1988).[3]

Repeatedly, this Court has recognized that freedom of thought is one of the most elementary and important rights inherent in the First Amendment.

In *West Virginia State Board of Education v. Barnette*, 319 U.S. 624 (1943), this Court, in an 8-1 decision, invalidated a school requirement that compelled a flag salute on the ground that it was an unconstitutional invasion of "the sphere of intellect and spirit which it is the purpose of the First Amendment to our Constitution to reserve from official control." *Id.* at 642. The First Amendment, declared this Court, gives a constitutional preference for "individual freedom of mind" over "officially disciplined uniformity for which history indicates a disappointing and disastrous end."

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[3] Professor Emerson makes the same point. Situating freedom of thought as the foundation of the First Amendment, he explains:

> Forming or holding a belief occurs prior to expression. But it is the first stage in the processes of expression, and it tends to progress into expression. Hence safeguarding the right to form and hold beliefs is essential in maintaining a system of freedom of expression. Freedom of belief, therefore, must be held included within the protection of the First Amendment. Thomas Emerson, THE SYSTEM OF FREEDOM OF EXPRESSION 21-22 (1970).

Id. at 637. At the center of our American freedom, is the "freedom to be intellectually and spiritually diverse." *Id.* at 641. "We can have intellectual individualism and the rich cultural diversities that we owe to exceptional minds," this Court explained, "only at the price of occasional eccentricity and abnormal attitudes." *Id.* at 641-42.

This principle, that freedom of thought is central to the First Amendment and protected thereby, has guided other important decisions of this Court. In *Wooley v. Maynard*, 430 U.S. 705 (1977), the Court invalidated a New Hampshire statute that required all noncommercial vehicle license plates to bear the state motto "Live Free or Die," finding the requirement inconsistent with "the right of freedom of thought protected by the First Amendment." *Id.* at 714.

In *Stanley v. Georgia*, 394 U.S. 557 (1969), this Court struck down a Georgia law that banned the private possession of obscene material, finding the law "wholly inconsistent with the philosophy of the First Amendment." *Id.* at 565-66. "Our whole constitutional heritage," explained this Court, "rebels at the thought of giving government the power to control men's minds." *Id.* at 565.

Justice Harlan, concurring in *United States v. Reidel*, 402 U.S. 351 (1971), characterized the Constitutional right protected in *Stanley* as "the First Amendment right of the individual to be free from governmental programs of thought control, however such programs might be justified in terms of permissible state objectives," and as the "freedom from governmental manipulation of the content of a man's mind...." *Id.* at 359 (Harlan J., concurring).

In *Abood v. Detroit Board of Education*, 431 U.S. 209 (1977), this Court invalidated a statute forcing public school teachers to contribute money to a union that advanced partisan political views. This Court characterized the case as one concerning "freedom of belief" and emphasized "freedom of belief is no incidental or secondary aspect of the First Amendment's protections... [A]t the heart of the First

Amendment," noted this Court, "is the notion that an individual should be free to believe as he will, and that in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State." *Id.* at 234-35.

B. The Government's Forcible and Direct Manipulation of a Person's Mental Processes Violates the First Amendment

The government is seeking to directly modify Dr. Sell's thoughts and thought processes by forcibly administering antipsychotic drugs designed to manipulate the chemistry of his brain and thereby change the way he thinks. The forcible administration of antipsychotic medication is not an effort to control Dr. Sell's behavior, with merely an incidental effect on his thinking. It is an effort aimed *directly* at changing his *mind* and *mental processes* by forcibly manipulating his brain chemistry. As such, this Court should recognize it as a serious affront to the First Amendment's protection of freedom of thought.

1. This Court's Rulings in *Harper* and *Riggins* Did Not Address A First Amendment Claim

In 1990, and again in 1992, this Court reviewed decisions in which defendants were medicated with psychiatric drugs against their will. However, in neither of those cases did the defendant raise a First Amendment freedom of thought claim.

In *Washington v. Harper* 494 U.S. 210 (1990), this Court (6-3) held that a state prisoner's "significant liberty interest" in refusing unwanted psychiatric drug treatment was constitutionally protected, but was outweighed by the state's interest in prison security. *Harper*, 494 U.S. at 221, 236. Harper was a post-conviction prisoner forced to take antipsychotic drugs on order of the prison psychiatrist. *Id* at 213-18. This Court acknowledged that "[t]he forcible injection of medication into a nonconsenting person's body

represents a substantial interference with that person's liberty." *Id.* at 229. This Court held, however, that when an inmate is dangerous to others and the treatment is in his best interest, the Due Process Clause permits the state to treat the inmate with antipsychotic drugs against his will. *Id.* at 227.

Harper is distinct from the instant case in two important ways. First, Harper was a post-conviction prison inmate, whereas Dr. Sell is a pretrial detainee. Harper's status as a prisoner, led this Court to apply the deferential "standard of reasonableness," which this Court has traditionally employed to decide constitutional claims in prisons. *Id.* At 223-24.[4] Second, unlike Dr. Sell, Harper was found to present "a danger to others," an important fact underscored by this Court:

> [w]here an inmate's mental disability is the root cause of the threat he poses to the inmate population, the State's interest in decreasing the danger to others necessarily encompasses an interest in providing him with medical treatment for his illness. *Id.* 494 U.S. at 225-26.

In *Harper*, this Court did not examine the possible First Amendment implications of forced psychiatric drug treatment. *Id.* at 258, n. 32 (Stevens J., concurring in part and dissenting in part). Additionally, because the case involved a dangerous post-conviction prisoner, rather than a nondangerous pretrial detainee deemed incompetent to stand trial, *Harper* provides background, but little guidance, for evaluating the claim in the instant case.

In *Riggins v. Nevada,* 504 U.S. 127 (1992), this Court suggested that *Harper* was to be read narrowly, noting that *Harper* turned on "the unique circumstances of penal confinement." *Id.* at 134-135. Riggins sought to raise an

[4] "[P]rison regulations...are judged under a 'reasonableness' test less restrictive than that ordinarily applied to alleged infringements of fundamental constitutional rights." *O'Lone v. Estate of Shabazz*, 482 U.S. 342, 349 (1987).

insanity defense to murder charges. During his trial he was medicated against his will with the antipsychotic drug Mellaril® (thioridazine HCl). His defense failed and he appealed his death sentence on the ground that the forced drugging violated his right to due process by manipulating his demeanor during trial and by hindering his ability to communicate with his attorney. In a 7-2 ruling, this Court reversed Riggins' conviction, finding that the trial court erred by failing to acknowledge Riggins' liberty interest in resisting the drugs, and by failing to examine whether any less intrusive alternatives to forced drugging existed. *Id.* at 133-37.

While both *Harper* and *Riggins* declared that a person has a "significant liberty interest" in resisting unwanted administration of antipsychotic drugs, neither case discussed: 1) the nature of that liberty interest; 2) whether it is a "fundamental" interest deserving of strict scrutiny; or 3) whether it could be overcome simply on a finding that the defendant was incompetent to stand trial. Most specifically, in neither case was a First Amendment freedom of thought claim presented or evaluated. As discussed in the following section, First Amendment principles are at the nexus of this case, and are clearly implicated when the state forcibly administers drugs intended and designed to alter the way a person thinks.

2. The First Amendment Right to Freedom of Thought Is Violated when the Government Forcibly Subjects a Person to Drugs or Other Technology for the Purpose of Directly Altering the Person's Thought Processes

a) Antipsychotic Drugs Manipulate the Brain With the Intent and Effect of Manipulating Thought

In the instant case, the Eighth Circuit has held that the state may forcibly inject a nondangerous citizen with mind-altering antipsychotic drugs for the sole purpose of making him competent to stand trial on fraud charges. *United States*

v. Sell, 282 F.3d 560 (2002). The Eighth Circuit's decision goes far beyond *Harper* or *Riggins*, or any other holding of this Court, concerning the power of the state to directly intrude into the innermost workings of a person's mind. The sweeping breadth of the Eighth Circuit's decision places freedom of thought in jeopardy, threatening the very foundation of the First Amendment as well as basic notions of individual freedom upon which this country was founded.

Sixty years ago this Court opined "[f]reedom to think is absolute of its own nature; the most tyrannical government is powerless to control the inward workings of the mind." *Jones v. Opelika*, 316 U.S. 584, 618 (1942). Since the advent of powerful antipsychotic drugs in the 1950s (as well as other technologies discussed in Section C2, *infra*), the government now *does have* the capability to "control the inward workings of the mind." The critical question, which the instant case frames for this Court, is whether or not the Constitution grants the government the power to alter a person's thinking processes against his or her will solely in an effort to render that person competent to stand trial. Here, the state seeks to forcibly change the way Dr. Sell *thinks*, by directly manipulating his brain chemistry.[5] Antipsychotic drugs, this

[5] The order granting the petition in this case limited the issue to whether petitioner's rights under the First, Fifth, and Sixth Amendments are violated by allowing the government to administer antipsychotic drugs to him against his will in order to make him competent to stand trial for nonviolent offenses. While the CCLE's brief is limited to articulating the First Amendment right to freedom of thought, the CCLE observes that government authorized forced drugging of a person with mind-altering drugs implicates other constitutional guarantees (federal and state) including the right to privacy, the rights guaranteed by the Fourth, Fifth, Sixth, Ninth, Tenth and Fourteenth Amendments, as well as International resolutions, laws, and treaties such as the UNIVERSAL DECLARATION OF HUMAN RIGHTS, adopted by the United Nations General Assembly. *See, e.g.*, William J. Brennan, *State Constitutions and the Protection of Individual Rights*, 90 HARV. L.

Court has noted, are "mind altering," and "[t]heir effectiveness resides in their capacity to achieve such effects." *Mills v. Rogers*, 457 U.S. 291, 293 n.1 (1982). These drugs "alter the chemical balance in a patient's brain, leading to changes...in his or her cognitive processes." *Harper*, 494 U.S. at 229.[6]

REV. 389 (1977); Michael Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?*, 20 LOY. L.A. L. REV. 1249, 1250-51 (1987); Bruce Winnick, *The Right to Refuse Mental Health Treatment*, AM. PSYCHOL. ASS'N, WASH., D.C. (1997); G.A. Res. 217, U.N. GAOR, 3rd Sess., at 71, U.N. Doc. A/810 (1948); *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, G.A. Res. 119, U.N. GAOR, 46th Sess., Supp. No. 49, Annex, at 188-92, U.N.Doc. A/46/49 (1991).

> It is obligatory that Helsinki signatory states not manipulate the minds of their citizens; that they not step between a man and his conscience or his God; and that they not prevent his thoughts from finding expression through peaceful action. *Hearings on Abuse of Psychiatry in the Soviet Union before the Subcomm. on Human Rights and Int'l Orgs. of the House Comm. on Foreign Affairs*, 98th Cong., 106 (1983) (remarks by Max Kampelman, Chair of the U.S. Delegation, to the Plenary Session of the Comm. on Security and Cooperation in Europe), quoted in *Harper*, 494 U.S. at 238, n3 (Stevens, J., dissenting).

[6] For many people, antipsychotic drugs may provide life-enhancing benefits. For others, the physical and mental side effects of the drugs may be unacceptable, even dangerous. *See, e.g., Harper*, 494 U.S. at 229 ("While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects"). The *medical efficacy* of anti-psychotic drugs, however, is *not* the issue in this case. Even in the absence of physical and mental "side effects," the fact remains that antipsychotic drugs strongly affect thought processes. The First Amendment should be read to allocate to the individual, as opposed to the government, the final say about whether to

Given that alteration of thinking is both the design and effect of antipsychotic drugs, permitting the government to *force* a citizen to take such drugs outside of the narrow context of *Harper*, cannot be squared with the supremely fundamental nature of the right to freedom of thought.

By forcing a person to take a mind-altering drug against his or her will, the government is commandeering that person's mind, and forcibly changing his or her very ability to formulate particular thoughts. *In re guardianship of Roe,* 421 N.E.2d 40, 52-3 (1981), ("the impact of the chemicals upon the brain is sufficient to undermine the foundations of personality.") By directly manipulating the manner in which a person's brain processes information and formulates ideas, the government *ipso facto* manipulates and alters both the form and content of that person's subsequent expression and thereby completely undermines the First Amendment's free speech guarantee.

Thus, a government action that directly and intentionally alters the way a person thinks by forcibly modifying that person's brain, directly violates the First Amendment right to freedom of thought. By manipulating the way that Dr. Sell thinks, through the forcible act of administering mind-altering drugs to him, the state commits a type of *cognitive* censorship—suppressing Dr. Sell's own thoughts in favor of state-approved, drug-induced, "normal," "acceptable," or "competent" thoughts.[7] Such state action is surely no less disfavored under the First Amendment than the censorship of speech.[8] A government that is permitted to

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manipulate his or her own brain for the purpose of occasioning or suppressing thoughts.

[7] It should be noted that antipsychotic drugs do not cure mental illness; rather they suppress the symptoms of the illness. *See* Gerald Davison & John Neale, ABNORMAL PSYCHOLOGY 305 (8th ed. 2001).

[8] Professor Shapiro has outlined the core logic of this proposition as follows:

manipulate a citizen's consciousness at its very roots does not need to censor speech, because it can prevent the ideas from ever occurring in the mind of the speaker.[9] Chemical or technological manipulation of the brain, therefore, has the potential to become the ultimate prior restraint on speech.[10]

If "at the heart of the First Amendment is the notion that...in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State" (*Abood,* 431 U.S. at 234-235), then there can be no doubt that the government infringes on the First Amendment when

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(1) The First Amendment protects communication of virtually all kinds, whether in written, verbal, pictorial, or any symbolic form, and whether cognitive or emotive in nature.

(2) Communication entails the transmission and reception of whatever is communicated.

(3) Transmission and reception necessarily involves mentation on the part of both the person transmitting and the person receiving.

(4) It is in fact impossible to distinguish in advance mentation that will be involved in or necessary to transmission and reception from mentation that will not.

(5) If communication is to be protected, *all* mentation (regardless of its potential involvement in transmission or reception) must therefore be protected. Michael Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237, 256 (1974).

[9] "If they can get you asking the wrong questions, they don't have to worry about the answers." Thomas Pynchon, GRAVITY'S RAINBOW 293 (Bantam Books 1974).

[10] "Any prior restraint on expression comes to...[the] Court with a 'heavy presumption' against its constitutional validity." *Organization for a Better Austin v. Keefe*, 402 U.S. 415, 419 (1971) (quoting *Bantam Books, Inc. v. Sullivan*, 372 U.S. 58, 70 (1963)).

outside the narrow context of *Harper* it acts to alter what, or how, a person thinks by forcibly and directly manipulating a person's brain.

b) Federal Courts Have Recognized a First Amendment Violation When the Government Forces a Person to Take Mind-Altering Drugs

Federal courts have recognized the First Amendment freedom of thought implications of government-ordered forced drugging with psychiatric drugs.

In *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973) a prisoner complained that he was being forced to take the drug succinylcholine, which he characterized as a "breath-stopping and paralyzing 'fright drug,'" (*id.* at 877) used at the time in aversive therapy. The Ninth Circuit reversed and remanded the case for a hearing on the prisoner's allegations, noting that "[p]roof of such matters could, in our judgment, raise serious constitutional questions respecting...impermissible tinkering with the mental processes." *Id.* at 878.

In *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), the Tenth Circuit found that the First Amendment is implicated when the government forcibly administers antipsychotic drugs to pretrial detainees. In *Bee*, a pretrial detainee brought suit after employees of the Salt Lake City Jail forcibly injected him with the antipsychotic drug thorazine.

Quoting this Court, the Tenth Circuit in *Bee* recognized that "liberty from bodily restraint always has been recognized as the core of the liberty protected by the Due Process Clause from arbitrary governmental action,"[11] and reasoned that "[i]f incarcerated individuals retain a liberty interest in freedom from *bodily* restraints...then a fortiori they have a liberty

[11] *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982), (quoting *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 18, (1979) (Powell, J., concurring in part and dissenting in part)).

interest in freedom from physical and mental restraint of the kind potentially imposed by antipsychotic drugs." *Bee,* 744 F.2d at 1393 (emph. in orig).

Most specifically, the Tenth Circuit found that the First Amendment is implicated when the government forcibly administers antipsychotic drugs to a person, explaining:

> The First Amendment protects the communication of ideas, which itself implies protection of the capacity to produce ideas. [Citations omitted] Antipsychotic drugs have the capacity to severely and even permanently affect an individual's ability to think and communicate. *Id.* at 1393-94.

Continuing, the Tenth Circuit in *Bee* observed:

> "In a society whose 'whole constitutional heritage rebels at the thought of giving government the power to control men's minds,' the governing institutions, and especially the courts, must not only reject direct attempts to exercise forbidden domination over mental processes; they must strictly examine as well oblique intrusions likely to produce, or designed to produce, the same result." L. Tribe, [*supra*] at 899 (1978) (quoting *Stanley,* [*supra*] 394 U.S. 557, 565...). *Bee,* 744 F.2d at 1394.

The Tenth Circuit's reasoning in *Bee* was followed by the Sixth Circuit in a case involving a pretrial detainee whom the government sought to forcibly drug in an effort to make him competent to stand trial. In *United States v. Brandon*, 158 F.3d 947 (6th Cir. 1998) the Sixth Circuit agreed with the *Bee* court that a pretrial detainee has, among other interests, "a First Amendment interest in avoiding forced medication, which may interfere with his ability to communicate ideas." *Brandon,* 158 F.3d at 953.

C. The Fundamental Right to Freedom of Thought Must Be Jealously Guarded By A Clear Bright-Line Rule

In light of the importance that this Court and federal

courts have placed upon the constitutional right of an individual to freedom of thought and integrity over his or her thought processes, it is imperative that this Court strictly circumscribe, and make unequivocally clear, the limits on the government's power to forcibly and directly alter the thoughts of citizens. The absence of such an unambiguous bright-line rule at the jurisprudential crossroads of psychiatry and technology, exposes the very foundation of the First Amendment to erosion, and grants "government the power to control men's minds." *Stanley,* 394 U.S. at 565.

1. Abuse and Misapplication of Mental Diagnosis Threatens to Undermine Freedom of Thought In the Absence of an Unequivocal and Narrow Rule

The former Soviet Union had a First Amendment equivalent, but it was merely an unenforced "paper" right. It was not uncommon for Soviet psychiatrists to forcibly drug political dissidents after labeling them "mentally ill." *See* Sidney Bloch & Peter Reddaway, PSYCHIATRIC TERROR: HOW SOVIET PSYCHIATRY IS USED TO SUPPRESS DISSENT (1977); *See also* James F. Clarity, *A Freed Dissident Says Soviet Doctors Sought to Break His Political Beliefs*, N. Y. TIMES, Feb. 4, 1976, at A1, 8. Similar political misuse of psychiatry reportedly continues today in the People's Republic of China. *See* Robin Munro, *Judicial Psychiatry in China and its Political Abuses*, Vol. 14, no.1 COLUM. J. ASIAN L. 1-128 (2000); Munro, *Political Psychiatry in Post Mao China and its Origins in the Cultural Revolution*, Vol. 30, n. 1 J. AM. ACAD. PSYCHIATRY & L. 97-106 (2002).

Even in the absence of overt political abuse, this Court has acknowledged that distinguishing "normal" thoughts from "abnormal" or "disordered" thoughts is fraught with peril: "the inquiry itself is elusive, for it presupposes some baseline of normality that experts may have some difficulty in establishing for a particular defendant, if they can establish it at all." *Riggins,* 504 U.S. at 141 (Kennedy, J.,

concurring).[12] Indeed, this Court has previously recognized that "[t]he subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations," because "[p]sychiatric diagnosis . . . is to a large extent based on medical impressions drawn from subjective analysis and filtered through the experience of the diagnostician." *Medina v. California*, 504 U.S. 437, 451 (1992), quoting *Addington v. Texas*, 441 U.S. 418, 430 (1979). "Psychiatry," this Court has observed, "is not...an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given

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[12] Dr. Robert Spitzer, chair of the American Psychiatric Association committees that developed two earlier versions of the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM) (DSM—III and DSM-III-R) and special advisor to the committee that developed the latest DSM (DSM-IV, 1994), has acknowledged that "[t]he concept of 'disorder' always involves a value judgment." Spitzer, *The Diagnostic Status of Homosexuality in DSM-III: A Reformulation of the Issues*, 138 AM. J. PSYCHIATRY 210, 214 (1981). For example, until 1972 the DSM defined homosexuality as a mental disorder. "Treatment," in addition to counseling, included penile plethysmograph shocks (electronic shock triggered by penile erection), drugging, and hypnosis. *See* N. McConaghy, *Subjective and Penile Plethysmograph Responses Following Aversion-Relief and Apomorphine Aversion Therapy for Homosexual Impulses*, 115 BRIT. J. PSYCHIATRY 723-730 (1969); B. James & D. Early, *Aversion Therapy for Homosexuality*, 1 BRIT. MED. J. 538 (1963); M. Feldman & M. MacCulloch, *A Systematic Approach to the Treatment of Homosexuality by Conditioned Aversion: Preliminary Report*, 121 AM. J. PSYCHIATRY 167-171 (1964); E. Callahan & H. Leitenberg, *Aversion Therapy for Sexual Deviation: Contingent Shock and Covert Sensitization*, 81 J. ABNORMAL PSYCHOL. 60-73 (1973).

In 1973, following intense debate within the American Psychiatric Association, the diagnostic disorder category of "homosexual" was removed from the DSM. *Spitzer, supra*, at 214.

behavior and symptoms, on cure and treatment...." *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985); *See also* Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 697-708, 729-32 (1974).

In light of the difficulties inherent in categorizing and diagnosing "disordered" thought, the government's power to "correct a person's thinking by manipulating the person's brain against his or her will, must be strictly and unambiguously limited.

2. Technological Developments Threaten to Undermine Freedom of Thought in the Absence of an Unequivocal and Narrow Rule

Vigorous protection of freedom of thought is particularly important today, given major advances in technology and pharmacology. Pharmaceutical companies are increasingly interested in the development and marketing of new drugs aimed at modulating consciousness by modifying brain chemistry. The sale of Prozac® and similar antidepressant drugs is currently one of the most profitable segments of the pharmaceutical drug industry.[13] Sales of "antipsychotic" drugs are currently the eighth largest therapy class of drugs with worldwide sales of $6 billion in the year 2000, a 22 percent increase in sales over the previous year.[14]

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[13] According to IMS Health, a fifty-year-old company specializing in pharmaceutical market intelligence and analyses, "antidepressants, the #3-ranked therapy class worldwide, experienced 18 percent sales growth in 2000, to $13.4 billion or 4.2 percent of all audited global pharmaceutical sales." IMS Health, *Antidepressants* (summary online <http://www.imshealth.com/public/structure/navcontent/1,3272,1034-1034-0,00.html>).

[14] *See* IMS Health, *Antipsychotics* (summary online <http://www.imshealth.com/public/structure/navcontent/1,3272,1035-1035-0,00.html>). A report published by the Lewin Group in January 2000, found that within the Medicaid program alone, "Antidepressant prescriptions totaled 19 million in 1998...[and] [a]ntipsychotic prescriptions totaled 11 million in 1998." Lewin Group, *Access and Utilization of New Antidepressant and Antipsychotic Medications* (Jan. 2000).

Machines such as brain imagers, brain monitors, and new biological interventions are rapidly increasing our knowledge of how the brain works, while simultaneously increasing the ability to monitor and/or alter its workings in both gross and subtle ways.[15] The development of such drugs and

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[15] Aside from growing applications of available brain scan devices including: functional magnetic resonance imaging f(MRI), positron emission tomography (PET), electroencephalographic monitoring (EEG); developments in fields related to nanotechnology point to possibilities for minute-scaled (physical, chemical, thermodynamic, mechanical, and biological) devices deployed in the body that would be capable of closer monitoring, intervention and manipulation. *See* Robert Freitas. NANOMEDICINE VOLUME 1: BASIC CAPABILITIES (1999), which methodically describes the capabilities of molecular machine systems that may be required by many, if not most, medical nanorobotic devices. These include: the abilities to recognize, sort, and transport important molecules; sense the environment; alter shape or surface texture; generate onboard energy to power effective robotic functions; communicate with doctors, patients, and other nanorobots; navigate throughout the human body; manipulate microscopic objects and move about inside a human body; timekeep, perform computations, and disable living cells and viruses. In Chapter One, Freitas writes "... most of us suppose that we are endowed with free will. But if choices by free will are simply the resolution of conflicts of neurological subsystems, and we become consciously aware of those subsystems and are able to intervene in their processes, do we run the risk of runaway instabilities at the deepest levels of what we presently call our 'minds'? Will we find that these instabilities are profound counterparts to the maladies we currently designate as epilepsy, or psychosomatic illnesses? In any redesigns of our brains which would involve opening doors to, quite literally, the ultrastructure of our thoughts, we could become 'naked to ourselves' in ways that we can only vaguely speculate about at

technologies is to be applauded for their potential to aid millions of suffering Americans who *voluntarily* use them. But the instant case raises the dark prospect of the government *forcibly* employing existing and new technologies to overtly or covertly alter the way that the populace, or individual citizens, think.[16]

As cautioned by Professor Winnick, "...a vast array of treatment technologies now exist that enable government for the first time to intrude directly and powerfully into an individual's mental processes and therefore pose a potential for abuse that cannot be ignored." *Winnick, supra*, at 8.

"Advances in the psychic and related sciences," conjectured Justice Brandies 75 years ago, "may bring means of exploring unexpressed beliefs, thoughts and emotions." *Olmstead* v. *United States*, 277 U. S. 438, 474 (1928) (Brandeis, J., dissenting opinion). Technological progress is indeed turning "mind control" fiction into fact, with the possibility that neurochemical drugs or other technology

present. Along with any other dangers we might encounter, this will raise entirely new issues of the proper role of psychotherapy and the sanctity of personal privacy." NANOMEDICINE, *supra*, Volume 1: Chapter 1.2 Current Medical Practice, § 1.2.5 "Changing View of the Human Body."

[16] Already, for example, at least one public school has reportedly mandated drugging a student with Dextrostat, (a version of Ritalin®) and Paxil,® in order to attend school. *See* Douglas Montero, *I Was Told To Dope My Kid*, N. Y. POST, Aug. 7, 2002; Karen Thomas, *Parents pressured to put kids on Ritalin: N.Y. court orders use of medicine*, USA TODAY, Aug. 8, 2000 ("An Albany, N.Y. couple put their 7-year-old son back on Ritalin after a family court ruled that they must continue medicating him for ADD."). *See also* Lehtinen, *Technological Incapacitation: A Neglected Alternative*, 2 Q. J. CORRECTIONS 31, 35-36 (1978) (Suggesting sub-dermal implanting of long-acting tranquilizers as an alternative to incarceration).

could be deployed as tools of individual and social control.[17] Already in use, and undergoing further development, is a "brain fingerprinting" machine, a brainwave-measuring device intended for law enforcement use. *See* United States General Accounting Office, *Investigative Techniques:*

[17] The 20th century imagination is peppered with ruminations on the coercive potential of electronic and chemical technologies. Variations on theme form the basis for countless dystopian novels, most notably NINETEEN EIGHTY-FOUR. ("Don't you see that the whole aim of Newspeak is to narrow the range of thought?...Every year fewer and fewer words, and the range of consciousness always a little smaller"). George Orwell, NINETEEN EIGHTY-FOUR 46 (Harcourt, Brace 1949); *see also*, *id*., Appendix "The Principles of Newspeak;" A psychoactive drug named "Soma" controls citizens' behavior in the novel BRAVE NEW WORLD. Aldous Huxley, BRAVE NEW WORLD, (Doubleday 1932); In A CLOCKWORK ORANGE, the protagonist, Alex, is conditioned into a docile model citizen through aversion therapy. Anthony Burgess, A CLOCKWORK ORANGE, (W. W. Norton 1963); In THE TERMINAL MAN, a man's violent tendencies are controlled by implanting electrodes into his brain. Michael Crichton, THE TERMINAL MAN, (Knopf 1972); In THIS PERFECT DAY inhabitants are genetically engineered and drugged daily into a calm state of mind. Ira Levin, THIS PERFECT DAY, (Random House 1970); In WOMAN ON THE EDGE OF TIME, the heroine is incarcerated in a mental hospital and subjected to a panoply of forced-drugs and is subjected to electrode implantation in the brain. Marge Piercy, (Knopf 1976); In SYNNERS, socket nanotechnology allows imperceptibly small brain implants to directly interface with a readily available cybernetic information network. Pat Cadigan, SYNNERS, (Bantam Spectra 1991); In MINDPLAYERS, mind-to-mind technology works by infusing a chemical bath of sedatives to the brain, then engaging skull caps connected directly to neurons. For the central character, this experience has the effect of "producing a change in brain chemistry that felt as natural as changing your mind" Pat Cadigan, MINDPLAYERS 4, (Bantam Books 1987); *See generally* Kenneth Melvin, Stanley Brodsky and Raymond Fowler, Jr., eds. PSY-FI ONE: AN ANTHOLOGY OF PSYCHOLOGY IN SCIENCE FICTION (1st ed.: Random House, 1977).

Federal Agency Views on the Potential Application of "Brain Fingerprinting." REPORT GAO-02-22, (Oct. 2001).

Dr. John D. Norseen, systems scientist for Lockheed Martin, has been quoted as saying "[w]e are at the point where... we can use a single electrode or something like an airport security system where there is a dome above your head to get enough information that we can know the number you're thinking." Sharon Berry, *Decoding Minds, Foiling Adversaries*, SIGNAL MAG., (Oct. 2001).[18]

The Department of Defense's Joint Non-Lethal Weapons Directorate (JNLWD) is exploring the use of various pharmaceutical psychoactive "calmative" agents in a number of contexts, including civilian crowd control by blanket sedation.[19] An October 2000 JNLWD report, notes that potential "use environments" for calmative drugs include "a group of hungry refugees that are excited over the distribution of food and unwilling to wait patiently," an "agitated population" and "riot and/or hostage situations." *Id.* at 3, 10. Examples of more tailored means of calmative drug distribution described in the report include "application to

[18] *Signal Magazine* is the Armed Forces Communications and Electronics Association's "Journal for Communications, Electronics, Intelligence, and Information Systems Professionals."

[19] *See* Joan Lakoski, W. Murray, John Kenny, *The Advantages and Limitations of Calmatives for Use as a Non-Lethal Technique*, U. PA, (Oct. 3, 2000) (report obtained by the Sunshine Project <http://www.sunshine-project.org> under a FOIA Request,) ("There are numerous pharmaceutical agents with a profile of producing a calm-like behavioral state currently available in clinical practice. Moreover, wide arrays of new compounds with unique cellular and molecular mechanisms are under development by the pharmaceutical industry for their ability to produce calm and tranquil-like states of behavior. Therefore, this report serves as an essential first step in identification of calmative pharmaceutical agents with potential utility as non-lethal techniques"). *Id.* at 6.

drinking water, topical administration to the skin, an aerosol spray inhalation route, or a drug-filled rubber bullet." *Id.* at 10.

As this Court noted in 1985, the U.S. government has, in the past, crossed ethical and legal lines by administering psychoactive drugs on unwitting civilians. *See CIA v. Sims*, 471 U.S. 159 (1985) ("Several MKULTRA subprojects involved experiments where researchers surreptitiously administered dangerous drugs, such as LSD, to unwitting human subjects. At least two persons died as a result of MKULTRA experiments, and others may have suffered impaired health because of the testing.").[20]

Recently, this Court observed with respect to the Fourth Amendment, that "[i]t would be foolish to contend that the degree of privacy secured to citizens by the Fourth Amendment has been entirely unaffected by the advance of technology.... The question...is what limits there are upon this power of technology to shrink the realm of guaranteed privacy." *Kyllo v. United States* 533 U.S. 27, 34 (2001). When that same question is asked about technological developments like those discussed in this section, the First Amendment guarantee of freedom of thought demands an answer by this Court that establishes unequivocal limits on the government's power to invade the inner workings of a

[20] *See also Final Report of the Select Comm. to Study Gov't Operations with Respect to Intelligence Activities*, S. Rep. No. 94-755, Book I, (1976); *Report to the President by the Comm'n on CIA Activities Within the United States* 226-228 (June 1975); *Project MKULTRA, the CIA's Program of Research in Behavioral Modification: Joint Hearings before the Select Comm. on Intelligence and the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources*, 95th Cong., 1st Sess. (1977); *Human Drug Testing by the CIA, 1977: Hearings on S. 1893 before the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources*, 95th Cong., 1st Sess. (1977).

person's mind.

D. Violating a Person's Fundamental Right to Freedom of Thought Solely to Advance the Government's Interest in Adjudicating Crimes Does Not Withstand Strict Scrutiny

To infringe on a fundamental right such as the First Amendment right to freedom of thought, the government must justify its action by no less a standard than strict scrutiny. *See N.A.A.C.P. v. Button*, 371 U.S. 415, 438 (1963) ("The decisions of this Court have consistently held that only a compelling state interest…can justify limiting First Amendment freedoms."); *Brandon,* 158 F.3d at 957 ("[T]o forcibly medicate [a non-dangerous pretrial detainee] the government must satisfy strict scrutiny review and demonstrate that its proposed approach is narrowly tailored to a compelling interest.").

1. The Government's Interest in Adjudicating Crimes Is, Standing Alone, Insufficiently Compelling to Justify Forcible Alteration of a Defendant's Thought Processes

To survive strict scrutiny, the governmental interest advanced "must be paramount, one of vital importance, and the burden is on the government to show the existence of such an interest." *Elrod v. Burns*, 427 U.S. 347, 362 (1976). Here, the sole interest asserted by the state is its "interest in bringing a defendant to trial." *Sell,* 283 F.3d at 568. While this is undeniably a *legitimate* governmental interest, the CCLE submits that it is insufficiently *compelling, by itself,* to override a person's First Amendment right to freedom of thought.

This Court should reject the Eighth Circuit's assertion that some charges are sufficiently "serious" to justify forced drugging with antipsychotics. *Sell*, 282 F.3d at 568. The CCLE submits that a bare determination of a defendant's incompetence to stand trial, regardless of the "seriousness" of the offense, may not, standing alone, serve as the overriding

justification for the state directly intruding into a person's brain and manipulating how he or she thinks. To permit such an important First Amendment right to turn on how various courts characterize the "seriousness" of offenses would invite confusion and inconsistent application of the law. One need only look at the Eighth Circuit's perfunctory conclusion that fraud and money laundering (nonviolent economic crimes), are "serious" enough to justify drugging Dr. Sell, to clearly glimpse how important it is for this Court to unequivocally state that a finding of incompetence to stand trial is, alone, insufficient to justify the government in forcibly administering mind-altering drugs to a defendant.

In the instant case, the Eighth Circuit affirmed that Dr. Sell is not a danger to himself or others. *Sell,* 283 F.3d at 565. ("Upon review, we agree that the evidence does not support a finding that Sell posed a danger to himself or others at the Medical Center"). Dr. Sell has merely been found incompetent to stand trial. The test for determining competence to stand trial is whether the defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him." *Dusky v. United States*, 362 U.S. 402, 402 (1960). Professor Winnick has suggested that the test for competency to stand trial should not be conflated with the test of competency to make medical treatment decisions, explaining: "at least some and perhaps many defendants found incompetent to stand trial are competent to make medical treatment decisions, it would [therefore] seem unconstitutional conclusively to presume that all defendants found incompetent to stand trial are also incompetent [to make their own medical decisions]." *Winnick, supra*, at 294, n.165.

Indeed this Court has recognized, "commitment and competency proceedings address entirely different substantive issues." *Cooper v. Oklahoma*, 517 U.S. 348, 368 (1996). Dr. Sell has *not* been found to be incompetent to

make his own *medical decisions*. In order to civilly commit a person, and thereby substitute the state's authority in treatment decisions for the person's own authority, this Court previously emphasized:

> ...due process requires at a minimum a showing that the person is mentally ill and either poses a danger to himself or others or is incapable of "surviving safely in freedom," *id.*, at 573-576. The test for competence to stand trial, by contrast, is whether the defendant has the present ability to understand the charges against him and communicate effectively with defense counsel. *Cooper*, 517 U.S. at 368.

Accordingly, simply because Dr. Sell has been declared incompetent to stand trial, the state must not, *ipso facto*, be handed the enormous power of reworking his brain and "correcting" his thoughts. A clear rule that the First Amendment prohibits the government from altering the way a person thinks merely because that person has been declared incompetent to stand trial, also comports with principles of fundamental fairness and other constitutional guarantees. As Justice Kennedy noted in his concurring opinion in *Riggins*:

> [c]ompetence to stand trial is rudimentary, for upon it depends the main part of those rights deemed essential to a fair trial, including the right to effective assistance of counsel, the rights to summon, to confront, and to cross examine witnesses, and the right to testify on one's own behalf or to remain silent without penalty for doing so. *Riggins* 504 U.S. at 139-140.

Justice Kennedy's comments underscore that the government's interest is not merely to bring defendants to trial, but to conduct a fair and just trial. *See Brecht v. Abrahamson*, 507 U.S. 619, 652 (1993) (O'Connor, J., dissenting) ("[T]he central goal of the criminal justice system...[is the] accurate determination of guilt and innocence"); *Estes v. Texas*, 381 U.S. 532, 542-43 (1965)

("The criminal trial under our Constitution has a clearly defined purpose, to provide a fair and reliable determination of guilt, and no procedure or occurrence which seriously threatens to divert it from that purpose can be tolerated.") "The Constitution," this Court has explained, "recognizes an adversary system as the proper method of determining guilt, and the Government, as a litigant, has a legitimate interest in seeing that cases in which it believes a conviction is warranted are tried before the tribunal which the Constitution regards as most likely to produce a fair result." *Singer v. United States*, 380 U.S. 24, 36 (1965).

It is precisely because our criminal justice system is *adversarial*, and because the Constitution demands a *fair trial*, that the government's "legitimate interest in seeing that cases...are tried," must not be found to encompass the power to forcibly drug its adversaries into "competence." Indeed, the Eighth Circuit's ruling turns "competence to stand trial" into a weapon against the defendant, by transforming it into a gruesome test that the defendant must pass in order to escape having his mental processes forcibly manipulated by the state. This turns the principles underlying the rule on their head. What pretrial detainee will feel safe raising the issue of trial competence when the result could well be a forced injection of mind-altering drugs?

Further, drugging a defendant with antipsychotics or other psychoactive drugs will likely affect the person's demeanor at trial and/or his or her testimony. As Justice Kennedy noted in his concurring opinion in *Riggins*:

> The avowed purpose of [antipsychotic] medication is not functional competence, but competence to stand trial. In my view, elementary protections against state intrusion require the State, in every case, to make a showing that there is no significant risk that the medication will impair or alter in any material way the defendant's capacity or willingness to react to the testimony at trial or to assist his counsel. Based on my understanding of the medical literature, I have substantial reservations that the State can

make that showing. *Riggins*, 504 U.S. at 140 (Kennedy, J., concurring).

This position was earlier expressed by the Tenth Circuit in *Bee*. There, the Tenth Circuit applied strict scrutiny after finding that a pretrial detainee has a constitutionally protected liberty interest in avoiding antipsychotic drugs. *Bee*, 744 Fd.3. at 1394. While remanding the case for further proceedings because the trial court granted the government's motion for summary judgment without a sufficient hearing, the Tenth Circuit expressed extreme skepticism that the government's interest in bringing a defendant to trial could *ever* be a sufficiently compelling reason to drug a detainee against his will:

> ...although the state undoubtedly has an interest in bringing to trial those accused of a crime, we question whether this interest could *ever* be deemed sufficiently compelling to outweigh a criminal defendant's interest in not being forcibly medicated with antipsychotic drugs. With their potentially dangerous side effects, such drugs may not be administered lightly. Generally speaking, a decision to administer antipsychotics should be based on the legitimate treatment needs of the individual, in accordance with accepted medical practice. A state interest unrelated to the well-being of the individual or those around him simply has no relevance to such a determination. The needs of the individual, not the requirements of the prosecutor, must be paramount where the use of antipsychotic drugs is concerned. *Id.* at 1395 (emph. added).

2. There Are Less Intrusive Means To Advance the Government's Interest

Under strict scrutiny analysis, the government's infringement on a fundamental right must be "narrowly tailored"[21] or "no greater than necessary or essential"[22] to

[21] *Florida Star v. B.J.F.*, 491 U.S. 524, 541 (1989); *Miller v.*

protect the governmental interest at stake.

> [E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental liberties when the end can be more narrowly achieved. Shelton v. Tucker, 364 U.S. 479, 488 (1960).

As the CCLE reads the record, far less intrusive therapies, such as psychotherapy, psychoanalysis, counseling, group therapy, and a panoply of behavior therapies have yet to be tried in the instant case. *Sell*, 282 F.3d at 563-64. Psychoanalytical treatments are non-invasive, and do not directly alter the electro-chemical status of the brain. They have virtually no side effects, nor do they run the risk of chemically altering Dr. Sell's demeanor at trial or of hindering his ability to communicate with counsel or the jury. Thus, they present a far less intrusive means of advancing the state's interest than does the forcible administration of mind-altering drugs.

Finally, if this Court upholds Dr. Sell's fundamental right to freedom of thought against government efforts to forcibly drug him into competence, the result will not be to grant him his freedom. Rather, both federal and state laws provide long-standing and comprehensive procedures for dealing with defendants who are found incompetent to stand trial. *See* R. Roesch & S. Golding, *Competency To Stand Trial* (1980) 48-49; 18 U.S.C. §§ 4241-4248; *Greenwood v. United States*, 350 U.S. 366, 373 (1956) ("[T]he bill [enacting 18 U.S.C. 4241 *et seq.*] was proposed by the Judicial Conference of the United States after long study by a conspicuously able committee, followed by consultation with

Johnson, 515 U.S. 900, 920 (1995) ("To satisfy strict scrutiny, the State must demonstrate that its...legislation is narrowly tailored to serving a compelling governmental interest").

[22] *Seattle Times Co. v. Rhinehart*, 467 U.S. 20, 32 (1984) (quoting *Procunier v. Martinez*, 416 U.S. 396, 413 (1974)).

federal district and circuit judges...[and] deals comprehensively with those persons charged with federal crime who are insane or mentally incompetent to stand trial"); *Riggins*, 504 U.S. at 145 (Kennedy, J., concurring) ("If the State cannot render the defendant competent without involuntary medicine, then it must resort to civil commitment, if appropriate, unless the defendant becomes competent through other means"); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) (noting that if a detainee is not competent to stand trial, the government may "institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen"). These existing systems protect society while also protecting the best medical interest of the individual. Following these established procedures protects the right to freedom of thought as well as the state's interest in adjudicating crimes.

As this Court observed nearly 100 years ago:

> There is...a sphere within which the individual may assert the supremacy of his own will and rightfully dispute the authority of any human government, especially of any free government existing under a written constitution, to interfere with the exercise of that will. *Jacobson v. Massachusetts*, 197 U.S. 11, 29 (1905).

A person's intellect is surely within that protected sphere. The right of a person to liberty, autonomy and privacy over his or her own thought processes is situated at the core of what it means to be a free person. It is essential to the most elementary concepts of human freedom, dignity, and self-expression, and demands this Court's steadfast protection. The right to sovereignty over one's own thought processes is the quintessence of freedom, and is protected by the First Amendment.

CONCLUSION

For the foregoing reasons, *amicus curiae* respectfully urges the Court to reverse the decision of the Eighth Circuit.

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No. 02-5564

IN THE
Supreme Court of the United States

CHARLES T. SELL,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

MOTION OF THE DRUG POLICY ALLIANCE FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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HOPP

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONER

1. The Drug Policy Alliance hereby moves for this Court's leave to file the annexed Brief *Amicus Curiae* in Support of Petitioner in this case.[1]

2. Established in 1994, the Drug Policy Alliance (formerly The Lindesmith Center) is dedicated to deepening public understanding and broadening debate about drug use and regulation – and to the studying and advancing alternative policies that are grounded in science, compassion, public health, and respect for human rights and individual autonomy. The Alliance is a non-profit, non-partisan organization with more than 20,000 members and active supporters nationwide.

3. The Alliance, through its Office of Legal Affairs, has participated, as record counsel or *Amicus Curiae*, in litigation in this Court and numerous other State and federal courts. *See, e.g., Ferguson v. City of Charleston*, 532 U.S. 67 (2001), *on remand*, 308 F.3d 380 (4th Cir. 2002); *U.S.Dep't H.U.D.v. Rucker*, 535 U.S. 125 (2002); *Board of Education, Ind. Sch. Dist. No. 92, Pottawatomie County v. Earls*, 122 S. Ct. 2559 (2002); *Marchwinski v. Howard*, 309 F.3d 330 (6th Cir. 2002); *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002); *Guam v. Guerrero*, 290 F.3d 1210 (9th Cir. 2002); *State v. Peppers*, 552 S.E.2d 288 (S.C. 2001).

4. A principal focus of the Alliance's research and litigation efforts has been the sensitive interplay between individual freedom, medical expertise, professional ethics, and government power. Thus, in *Ferguson* and related South Carolina litigation, the Alliance – in conjunction with a broad

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[1]Although the United States consented to the filing of the Brief, we were unable to obtain the consent of Petitioner's counsel.

coalition of doctors, public health experts, and bioethicists – asked the courts to vindicate the principle that all patients, including indigent women with substance abuse problems, are entitled to give (or withhold) informed consent before medical treatment may be administered, and we highlighted the unintended dangers of government intrusion on the therapeutic relationship between physicians, nurses and their patients.

In a more recent set of cases, Alliance attorneys are representing physicians concerned about government interference with their ability to provide adequate, medically appropriate palliative medication to patients who are suffering from acute pain, *see Washington v. Glucksberg*, 521 U.S. 702 (1997), and who, having been fully informed of the benefits and risks, desire such therapy.

5. This case, which arises from a government effort to force hazardous, potent, mind-altering substances upon a non-dangerous individual against his will – solely that he might be made "competent" enough to stand trial for a non-violent offense – touches upon both the Alliance's basic mission and the practical work it seeks to accomplish. As in matters in which we have been more centrally involved, the decision under review evinces insufficient concern for basic interests of bodily integrity and individual self-determination and attaches undue weight to the benevolent (or legitimate) purposes advanced in support of government infringement. The decision also appears to accept troubling and empirically doubtful assumptions about the competence and legal rights of members of a vulnerable group, and the case raises unsettling questions about the nature of the relationship between individuals and their government-provided doctors.

6. In view of our experience and ongoing involvement with these matters, and our abiding commitment to the legal

principles this case implicates, the Drug Policy Alliance respectfully requests that the Court grant us leave to participate as *Amicus Curiae*.

Respectfully submitted,

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Interest of *Amicus Curiae*[*]

Established in 1994, the Drug Policy Alliance (formerly The Lindesmith Center) is dedicated to broadening the public debate over drug use and regulation and to advancing realistic policies, grounded in science, compassion, public health, and respect for human rights and individual autonomy. The Alliance is a non-profit, non-partisan organization with more than 20,000 members and active supporters nationwide. Through its Office of Legal Affairs, the Alliance has participated, as record counsel or *Amicus Curiae*, in litigation in this Court and various State and federal courts of appeals, concerning matters such as drug testing; access to substance abuse treatment and to treatment for patients suffering from severe and chronic pain; policies that disadvantage individuals with drug convictions or substance abuse problems and their families; and the use of medical marijuana and sacramental cannabis. At the core of these efforts is both concern that the fears, prejudices, and misconceptions that have, with regrettable frequency, infected this Nation's policies not be permitted to distort its constitutional law, and faith that courts will not permit government action, however well-intended, to trammel fundamental constitutional rights.

This case, which arises from government efforts to force hazardous, potent, mind-altering substances upon a non-dangerous individual against his will – solely that he might be made "competent" enough to stand trial for a non-violent offense – touches on matters of central concern to the Alliance.

Summary of Argument

By declining to apply the most demanding mode of judicial scrutiny, the Court of Appeals necessarily held that no liberty

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[*]This brief was not authored in any part by counsel for a party, and no one other than *Amicus* made a monetary contribution to its preparation or submission. Respondent, but not Petitioner, consented to its submission.

interest implicated here – including the freedom of a competent, non-dangerous individual to decide whether or not to ingest potent substances intended to alter his brain chemistry and thought processes (and known to threaten serious physical harm) – is "fundamental" under the Constitution.

Although no decision of the Court has specifically pronounced this freedom to be "fundamental," *see Riggins v. Nevada*, 504 U.S. 127, 136 (1992) (declining to prescribe level of scrutiny), both precedent and constitutional principle compel that conclusion.

The premise on which Petitioner's claim rests – that the individual is "sovereign over his own body and mind," J.S. MILL, ON LIBERTY 11 (Norton ed. 1975) – is one that is implicit in the concept of ordered liberty and that has found consistent expression in the common law; in this Court's First, Fourth, and Fifth Amendment jurisprudence; and in its decisions describing the "realms" where, as a matter of Due Process, "the state cannot enter."

Forcible administration of medication is itself a substantial infringement on dignity and bodily security, and as this Court's recent decisions describe, the specific drugs here at issue are potent and invasive in their intended operation. Their unintended effects can be disturbing, debilitating, even lethal.

To be sure, the benefits of these drugs are such that many individuals risk their dangers and endure their adverse effects, but those harms surely highlight the seriousness of divesting Petitioner of power to make the decision for himself. The common law and Due Process precedents underlying Petitioner's claim do not rest on the assumption that the individual is better situated than a government doctor to determine what is "medically appropriate," but rather that, in making important decisions concerning his body and mind, the

individual must be free to reject medical expertise or evaluate in light of personal experiences and broader conceptions of what is right, important and meaningful in life.

That this case involves a government effort to alter Petitioner's brain, with the avowed intent of changing his thought process, provides further, urgent reason for stringent scrutiny. There is no need to impute to doctors and officials in this case any sinister "mind control" agenda to recognize that government action that seeks to change a person's thinking, against his will, is deeply at odds with longstanding conceptions of constitutional "liberty." The Constitution protects private thoughts, ideas, and feelings – including those (such as Petitioner's, perhaps) unlikely to spark the discovery of broader political and philosophical truths – and its various express guarantees presuppose that an individual controls his own thinking process.

These concerns cannot be defined away by describing the action as "restoring" the individual to his "true self" – or as enhancing the quality or coherence of his thinking. Not only do such metaphors entail important oversimplification, and it but they run aground on a more basic objection: that the power to define oneself (or to choose among "better" or worse versions) is precisely what the Due Process Clause denies the government. If decisions concerning family, procreation, and child-rearing are "fundamental" based on their nexus to "personhood," then similar protection for the individual's mental life – his personality – must follow *a fortiori*.

Nor does acknowledgment that certain individuals lack capacity to make treatment decisions for themselves make these liberties less fundamental, either for those persons or others who, though mentally ill, retain that capacity. The assumption that individuals suffering from mental illness are incapable of

giving (and withholding) informed consent, though long clung to, has been disproved as a matter of fact and has been repudiated, almost universally, as a matter of law. And it has been a central teaching of this Court's liberty jurisprudence that such discredited preconceptions may not be allowed to deprive individuals of fundamental interests.

Although *Amicus* would submit that the constitutional stature of the liberty interest asserted does not depend on the context in which this case arises, the criminal trial setting surely strengthens Petitioner's claim to have his decision respected. The government intervention here is not even ostensibly therapeutic – the United States sought the order not as *parens patriae*, but as Petitioner's adversary in a criminal proceeding – and the interests Petitioner asserts, to be free from substances that will alter his cognition, appearance, sense of well-being, and affect, are bound inextricably with core rights guaranteed the accused under the Fifth and Sixth Amendments.

Finally, although this case does not call for a categorical pronouncement, we submit that – unlike the government's interests in preventing harm to others and in providing for the well-being of those without capacity to do so – the interest advanced here, described as that of "obtaining an adjudication of guilt or innocence," is not sufficiently "compelling" to support the infringement of liberty. The government's only legitimate interest is in obtaining a fair and accurate adjudication, a result that involuntary medication by no means necessarily advances, *see Riggins* (Kennedy, J., concurring in judgment). And unlike the other, long-recognized rationales for involuntary medical treatment, this awkwardly described interest rests on a jarring assumption: that the government's interest in obtaining a not guilty verdict should override the wrongly accused individual's interest in remaining free of potent, potentially lethal substances. Finally, unlike other

interests that are truly compelling, the interest in a prompt, dispositive adjudication is one the government itself regularly subordinates, in the pursuit of other interests, both important and constitutionally mundane.

I. Forcible Administration Of Potent, Mind-Altering Substances Requires Strict Scrutiny

In *Washington v. Glucksberg*, the Court reaffirmed that certain liberty interests are so firmly rooted in the "Nation's history and constitutional traditions" that Due Process allows their infringement only by government action narrowly tailored to achievement of a compelling interest. 521 U.S. 702, 721 (1997).[1] Although the decision below acknowledged that the Government's effort to administer antipschytoic drugs, over Petitioner's objection, implicated a "liberty" interest under the Constitution, *see* 282 F.3d at 565-66 (citing *Riggins* and *Washington v. Harper*, 494 U.S. 210 (1990)), it expressly refused to undertake the searching scrutiny indicated when "fundamental" freedoms are threatened, *id.* at 567 n.7.

Neither the Eighth Circuit's stated reasons nor this Court's precedents support that decision. First, *Riggins* did not, as the Court of Appeals indicated, "decline" to apply strict scrutiny, *id.* at 567 – it declined to decide the level-of-scrutiny question, *see* 504 U.S. at 136 – and *Harper* relied on precisely the mode of analysis that applies whenever "fundamental" rights are asserted against prison officials. *Turner v. Safley*, 482 U.S. 78, 89 (1987) (deciding "reasonableness" of restriction on right to marry); *O'Lone v. Estate of Shabazz*, 482 U.S. 342 (1987).

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[1] Although this case involves the Due Process Clause of the Fifth Amendment and not (as do many of the cited precedents) the identically-worded Fourteenth Amendment clause, the substantive liberties the two provisions protect are coextensive. *See Ingraham v. Wright*, 430 U.S. 651, 672 (1977); *see also Bolling v. Sharpe*, 347 U.S. 497, 500 (1954).

In fact, principled application of this Court's precedents compels the conclusion that the freedom at stake here – that of a non-dangerous individual (convicted of no crime) to decide against administration of powerful, mind-altering substances – is "fundamental."

A. Under This Court's Precedents. Petitioner's Bodily Integrity And Autonomy Interests Are Fundamental

The measures the Government seeks to take – intramuscular injection of powerful chemical agents intended to alter Petitioner's thinking process – are an undeniable imposition on his bodily integrity and "physical security"– interests long recognized as "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. 319, 326 (1937), and thus, fundamental. *See Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 287 (1990) (O'Connor, J., concurring) (the "Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause"); *Rochin v. California*, 342 U.S. 165 (1952); *Ingraham*, 430 U.S. at 673; *United States v. Stanley*, 483 U.S. 669, 685 (1986) (O'Connor, J., concurring) (quoting Nuremberg Tribunal's conclusion that "voluntary consent of the human subject [to medical experiment] is absolutely essential * * * to satisfy moral, ethical and legal concepts"); *see also Pratt v. Davis*, 118 Ill. App. 161, 166 (1905) ("under a free government at least, the free citizen's first and greatest right, which underlies all others [is] the right to the inviolability of his person").

Although antipsychotic drugs are not the most invasive intervention conceivable, *see, e.g.*, B. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT (1997) 103-115 (discussing psychosurgery), the methods by which they are administered to unwilling individuals go far beyond what is "routine in our everyday life," *Breithaupt v. Abram*, 352 U.S.

432, 436 (1956). *See Harper*, 494 U.S. at 229 ("[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty"). *Compare Breithaupt*, 432 U.S. at 436 (describing taking of blood, which "literally millions of us" have experienced) *and Jacobson v. Massachusetts*, 197 U.S. 11, 32 (1905) (noting pervasive vaccination of schoolchildren) *with* Joint App. *Mills v. Rogers*, No. 80-1417 at 170-71 (patients were "physically restrained, pants removed, injected with antipsychotic drugs through a hypodermic needle in the buttocks, at times in full view of other patients or staff"). Injection is not a one-time occurrence, *compare Rochin* (stomach pumping); *Winston v. Lee*, 470 U.S. 753 (1985) (surgical procedure), and because "there is no accurate method of determining how a patient will respond to a particular drug," selection of medication and dosage levels are arrived at on a "trial and error" basis. W. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 946 (1998).

Once injected, the drugs operate directly on the brain's chemistry, in ways that are not fully understood, and that have been found to have lasting effect on brain structure. *See* P. Harrison, *Review: The Neuropathological Effects of Antipsychotic Drugs*, 40 SCHIZOPHRENIA RES. 87-99 (1999). Moreover – without stinting the efficacy of these medications or the genuine relief that they have brought to many suffering from mental illness (and without suggesting that Petitioner's decision is in any objective sense "correct", *see infra*) – judicial notice has been taken of the "serious, even fatal, [physiological] side effects" these drugs cause. *Riggins*, 504 U.S. at134; *see* B. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1, 70 (1989) (underscoring that, although adverse effects are

"unintended, they are intrinsic to the drugs' benevolent properties and should not be trivialized, particularly since patients frequently experience them to be distressing enough to outweigh the drugs' positive clinical effects"); *cf. Stone v. Smith, Kline & French Labs.*, 731 F.2d 1575 (11th Cir. 1984) (sustaining conclusion that that Thorazine is "unavoidably unsafe" under RESTATEMENT (SECOND) OF TORTS § 402A); *Winston*, 470 U.S. at 761 (citing cases disallowing surgical procedures that, while likely to uncover evidence, would "endanger[] the life or health of [a] suspect").[2]

Among the documented effects of standard antipsychotic drugs are sedation, blurred vision, serious blood disorders, and an array of neuromuscular effects, including Akathesia – "uncontrollable physical restlessness, agitation, pacing, anxiety and panic"; Akinesia – a "state characterized by unspontaneous

[2]We note that newer, "atypical" antipsychotic drugs have been found to present side effect profiles that are different from and, in some respects less serious than those canvassed in *Riggins*. *See, e.g.*, D. Siegel, et al., *Old Law Meets New Medicine: Revisiting Involuntary Psychotropic Medication of the Criminal Defendant*, 2001 WIS. L. REV. 301, 349.

Although all should hope that these recently introduced agents fulfil their promise of delivering greater relief, with less onerous adverse effects, it bears emphasis that the long-term effects of these drugs remain largely unknown and that, like the far more prevalent, "typical" medications, they are indisputably potent, mind-altering substances, which can cause serious adverse health effects. *See infra*. Their relevance to Petitioner's case is further limited because (a) few of these drugs are currently available in a form (*i.e.*, injectable) that can be administered involuntarily, and (b) Petitioner suffers from delusional disorder, rather than schizophrenia, *see* DSM-IV-TR at 324, the disorder for which their therapeutic efficacy principally has been claimed.

But in any event, the Constitution's protection for self-determination in these matters is not dependent on any particular balance of harms and benefits.

speech, apathy and a difficulty in initiating activities"; dystonia – which is "characterized by muscle spasms, particularly in the eyes, neck, face and arms"; and tardive dyskinesia – a late-developing, often irreversible and untreatable condition characterized by involuntary movements of facial, arm, leg, or truncal musculature and, in more serious cases, by "difficulty [in] swallowing, talking and breathing ." Brooks, 31 IND. L. REV. at 947-49. Although newer antipsychotics have not been associated with tardive dyskinesia, they by are no means free of neuromuscular or other, even more serious, adverse effects.[3]

Significantly, some of these effects are themselves misunderstood and poorly diagnosed. For example, "[b]ecause psychiatrists often misinterpret symptoms of akathesia as a

[3]For example, 13% of those taking ziprasidone experience akathsia and 7% experience dystonia, rates that are substantially lower than those for Haloperidol (17% and 20%, respectively), but remain significant. *See* http://cebmh.warne.ox.ac.uk/cebmh/elmh/schizophrenia/tx/antipsychotics; *See* also B. WINICK, *supra* at 77 n. 80 (noting connection between clozapine and agranulocytosis, a serious hemological disorder).

Moreover, neuroleptic malignant syndrome (NMS) – which causes fever, skeletal rigidity, elevated blood pressure, delirium, mutism, stupor and coma and, in an estimated 20% to 30% of cases, death – has been associated with atypical, as well as typical drugs. J. Karagianis, et al. *Clozapine-Associated Neuroleptic Malignant Syndrome*: 33 ANN. PHARMACOTHERAPY 623-30 (1999). Although "relatively rare," *Riggins*, 504 U.S. at 134, "a conservative estimate would place the annual prevalence of neuroleptic malignant syndrome in the United States in the thousands of cases." H. Pope, et al., *Frequency and Presentation of Neuroleptic Malignant Syndrome in A Large Psychiatric Hospital*, 143 AM. J. PSYCH. 1227, 1231 (1986). *See also* D. Pinals & P. Buckley, *Novel Antipsychotic Agents and Their Implications for Forensic Psychiatry*, 27 J. AM. ACAD. PSYCH. & L. 7 (1999) (other effects of atypical drugs "include orthostatic hypotension, tachycardia (an abnormally fast heartbeat), excessive salivary flow, sedation, elevated temperature, weight gain, agitation, insomnia, headaches, nausea, sedation, constipation, dyspepsia, and somnolence").

worsening of a patient's psychiatric condition, physicians will react by increasing the dosage level of medication." Brooks, 31 IND. L. REV. at 948 (citing P. Weiden, et al., *Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study*, 144 AM. J. PSYCH. 1148, 1151 (1987)), and medications used to manage neuromuscular effects cause their own adverse effects. *See* S. Marder, *Schizophrenia: Somatic Treatment*, in KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCH. 1199, 1205 (B. Sadock & V. Sadock eds., 7th ed. 2000).

Even then, the drugs are not a "cure." A significant minority of patients do not respond to them at all, *see* B. WINICK, *supra*, and, for those who respond positively, the beneficial effects require continuous medication. *See Riese v. St. Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199 (Cal. App. 1987) ("The drugs are palliative rather than curative"). They have relatively little effect on "negative" symptoms of pscychosis, *i.e.* "social isolation, apathy, and decreased communicativeness" – which are both "debilitating" and"more significant for prognosis and over-all outcome [than] the symptoms * * * amendable to a pharmacological approach." S. Keith, *Drugs: Not the Only Treatment*, 33 HOSP. & COMMUNITY PSYCH. 793 (1982).

While the variety and intensity of these physical effects (along with effects on mentation, *infra*, individuals' subjective experience of their unmedicated state, their prior responses to medication, and their concepts of health and autonomy) help to make refusal decisions comprehensible, *see Harper*, 494 U.S. at 239 (Stevens, J, concurring in part, dissenting in part) (noting prison records indicating that respondent had "stated he would rather die th[a]n take medication"), they do not establish that that they are "medically inappropriate" or that, in any

objective sense, their burdens outweigh their benefits.[4]

On the contrary, it is a measure of their therapeutic benefit that many more individuals continue to consent to, rather than refuse, their administration, and those who do often report dramatically positive results. *Cf. Rogers v. Okin*, 478 F. Supp. 1342, 1369 (D. Mass.1979) (noting that only 12 of 1,000 institutionalized patients refused psychotropic drugs for prolonged periods during pendency of judicial supervision), *modified*, 634 F.2d 650 (1st Cir.1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982). And while the evidence of appropriateness in this case is disturbingly thin,[5] the

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[4]Notably, studies confirm that objectively verifiable adverse effects are a prominent reason for drug refusal. T. Van Putten, et al., *Subjective Response to Antipsychotic Drugs*, 38 ARCHIVES GEN. PSYCH. 187, 189-90 (1981); *see also* S. Hoge, et al., *A Prospective Multicenter Study of Patients' Refusal of Antipsychotic Medication*, 47 ARCHIVES GEN. PSYCH. 949, 954 (1990) (35% of patients cited side effects as reason for refusal, but treating physicians identified patient concern about side effects in only 7% of cases).

[5]The Court of Appeals pronounced that the district court had not committed "clear error" in concluding that "clear and convincing" evidence that antipsychotic medication was "medically appropriate" in Petitioner's case. *See* 282 F.3d at 570. At the outset, the appellate court opinion betrays a more causal approach to the record evidence than that standard contemplates – *e.g.*, characterizing a doctor as having a "50% success rate," *id.*, when he had testified that he had only encountered two such cases.

Even more significant, Petitioner presented psychiatric testimony that antipsychotic drugs were far less effective in treating his condition, delusional disorder, than schizophrenia, supported by a medical text confirming that assertion and a report from the forensic psychologist at Petitioner's detention facility stating that "delusional disorders do not typically respond to medication," *id.* Although the court described the treatise as noting "disagreement between experts" on the point, and quoted the testimony of the government's witness to the effect that – based on seven patients he had treated – "he doubted the accuracy," *id.* at 569, of the the medical literature concerning delusional disorder, it almost surely was clear

medical literature consistently reports benefits for large percentages of people who take them, *see Harper*, 494 U.S. at 226 n.9, and, for many individuals, no comparably effective alternative treatment is known. *See Riese*, 271 Cal. Rptr. at 203 (describing antipsychotic medication as "principal and single most effective treatment" for acute psychoses). It is unsurprising that individuals who have first-hand experience with these benefits would be puzzled or disturbed by judicial respect for an individual's decision not to take them. *Cf. Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 852 (1993) (protecting woman's freedom to make abortion decision, though noting that it is viewed by "some [as] nothing short of an act of violence against innocent human life").

But to state these real benefits and (no less real) risks is to underscore another fundamental aspect of liberty implicated here: the individual's freedom to decide whether or not to accept medical treatment, however appropriate. That freedom was implicitly recognized in *Riggins* – which established that "medical[] appropriate[ness]" is a necessary, but not sufficient precondition for involuntarily administering antipsychotic drugs, *see* 504 U.S. at 135 – and like the closely related interest in bodily security, it is rooted in basic concepts of self-ownership.

As *Cruzan* and *Glucksberg* document, the right to decide whether to accept medical treatment is "firmly entrenched in American tort law," 497 U.S. at 267, and protected by the Due Process Clause. *See Meyer v. Nebraska*, 262 U.S. 390, 399

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error for a court to have determined that the evidence on this point was "clear and convincing." *See United States v. Montague*, 40 F.3d 1251, 1255 (D.C. Cir. 1994) (describing that evidentiary standard as "most akin to the process of evaluating testimony 'in a light most favorable to the defendant'").

(1923) (defining as fundamental, "those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men"); *cf. Rogers*, 634 F.2d at 653 (calling it "intuitively obvious" that "a person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to the serious and potentially harmful medical treatment that is represented by the administration of antipsychotic drugs").

This right has been held effective against interventions that are less physically disruptive than those at issue here, *Cruzan* (assuming constitutional "right to refuse lifesaving hydration and nutrition"); *In re Osborne*, 294 A.2d 372 (D.C. 1972) (refusing to order blood transfusion), where the therapeutic benefit is both more clear and more enduring, *id.* (noting that transfusion would quickly restore health), where the alternative is more stark, *In re Quackenbush*, 383 A.2d 785 (N.J. Super. 1978) (death within three weeks, in the absence of amputation); *Lane v. Candura*, 376 N.E.2d 1232 (Mass. 1978); and where the reasons for refusal are inscrutable or eccentric, *see id. See also Application of President & Directors of Georgetown College, Inc.*, 331 F.2d 1010, 1016-17 (D.C. Cir. 1964) (Burger, J., dissenting) (right of privacy includes "great many foolish, unreasonable and even absurd ideas * * * such as refusing medical treatment even at great risk").

The reasons why law nonetheless treats the individual's decision as inviolable are rooted in respect for autonomy. In most cases, as here, the competing benefits and burdens are experienced overwhelmingly, usually exclusively, by the patient. *See* 282 F.3d at 565 (sustaining district court finding that Petitioner is not dangerous to others); *Casey*, 505 U.S. at 852 (noting that the "mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear" and concluding that State's interest in compliance

with its "vision of the woman's role" did not allow it to "insist * * * she make the sacrifice"); *Pratt*, 118 Ill. App. at 166 (patient's "right to himself * * * necessarily forbids a physician or surgeon, however skillful * * * to violate without permission [his] bodily integrity").[6]

Further, even where the competing benefits and risks can be roughly quantified – a 50% chance that a condition will improve as a result of invasive therapy, but a 10% chance that medication will produce a different, undesirable effect – there is often no obvious, objective basis for identifying the "correct" choice. *Cf. Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) ("The weighing of these risks against the individual subjective fears and hopes of the patient * * * is a nonmedical judgment reserved to the patient alone").

The law recognizes that how individuals reach decisions under these circumstances is inescapably personal, summoning their values, ethical and religious principles, and conceptions of what makes their own lives worthwhile and meaningful – realms where government (and medical science), to the limited extent they are competent to speak, may not exercise a veto. *West Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1944); *Casey*, 505 U.S. at 851 ("At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."); *In re*

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[6]In contrast, autonomy rights sometimes yield where other individuals are directly threatened. *See Riggins*, 504 U.S. at 135 (antipsychotic medication permissible if "medically appropriate and, considering less intrusive alternatives, essential for the sake of * * * the safety of others"); *Jacobson*, 197 U.S. at 26 (danger of smallpox outbreak); *see also Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*, 201 A.2d 537 (N.J. 1964) (requiring blood transfusion in case of woman carrying 34-week-old fetus). Notably, the inmate plaintiff in *Harper* was found to have been dangerous without medication. *See* 494 U.S. at 217.

Osborne, 294 A.2d at 374 (declining to order blood transfusion for patient who believed that it would deprive him entry to "new world where life will never end"). *See generally Belchertown State School v. Saikewicz*, 370 N.E. 2d 417 (Mass. 1977) (the "right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice"); *Rivers v. Katz*, 495 N.E. 2d 337, 343 (N.Y. 1986).

B. Actions Impinging On Mental Autonomy Warrant Special Constitutional Concern

That this case entails an unwanted intrusion directed at the individual's brain, with the avowed purpose of altering his thought process, *see Harper*, implicates special constitutional concern – and can not possibly supply a rationale for less vigilant constitutional scrutiny. *See* L. TRIBE, AMERICAN CONSTITUTIONAL LAW 1312 (2d ed. 1988) (describing "attempt to determine the contents and processes of mind" as the "starkest form of government invasion of personality"); *cf. Rochin*, 342 U.S. at 173 ("It would be a stultification of [judicial] responsibility * * * to hold that in order to convict a man the police cannot extract by force what is in his mind but can extract what is in his stomach").

In arguing that the exercise of sovereignty over the mind is entitled to special protection, we do not rely on (and would explicitly disavow) any suggestion that administration of antipsychotic drugs under these circumstances constitutes "mind control" – with its sinister connotations of suppressing government-disapproved ideas and replacing them with thoughts more acceptable to those in power, *see Barnette*, 319 U.S. at 643. Nor do we suggest that government need be strictly neutral between ordered and disordered thinking or that

delusions (such as Petitioner's) carry any significant potential to promote "the discovery * * * of political truth." *See Whitney v. California*, 274 U.S. 357, 375 (1927) (Brandeis, J., concurring); *but cf.* R. LAING, THE POLITICS OF EXPERIENCE 129 (1967) (predicting that society would eventually come to see "that what we call 'schizophrenia' []as one of the forms in which, often through quite ordinary people, the light began to break through the cracks in the all-too-closed minds").

But even with these provisos in place, the power to "alter the chemical balance in a patient's brain, leading to changes, * * * in his or her cognitive processes," *Harper*, 494 U.S. at 214 – even if undertaken with the aim of "enabling" thought processes – is one in grave tension with basic understanding of constitutional "liberty." This Court's cases have repeatedly recognized that the realm of thought is one more completely privileged against government intrusion than conduct, or even expression. *Stanley v. Georgia*, 394 U.S. 557, 565-56 (1969); *Jacobson v. United States*, 503 U.S. 540, 551-52 (1992) ("a person's inclinations and 'fantasies * * * are his own and beyond the reach of government'") (quoting *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 67 (1973)); *Jones v. Opelika*, 316 U.S. 584, 618 (1942) (Murphy, J., dissenting) ("[f]reedom to think is absolute of its own nature; the most tyrannical government is powerless to control the inward workings of the mind."), *rev'd*, 319 U.S. 103 (1943)); *see also Wooley v. Maynard*, 430 U.S. 705, 714 (1977) (describing free speech as a "component[] of the broader concept of individual freedom of mind").[7]

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[7]Although we describe this liberty in Fifth, rather than First Amendment terms – in view of the inseparability of Petitioner's bodily and mental integrity claims – the Court's First Amendment doctrine would surely indicate a similar result. Notably, though the precedents cited above are often referred to as "First Amendment" decisions, they are more precisely

The rationale for treating thought processes as largely "beyond the reach of government" rests not on the notion that they are "harmless," but rather on the understanding that they are important, because other freedoms the Constitution guarantees presuppose autonomous thought. Thus, "[f]reedom of expression would be illusory if government could intrude directly into mental processes to alter the very thoughts, beliefs, or attitudes that would be expressed," Winick, 44 U. MIAMI. L. REV. at 31, and as Justice Cardozo famously asserted, "freedom of thought" is "the matrix, the indispensable condition, of nearly every other form of freedom." *Palko*, 302 U.S. at 327; *see also Riggins*, 504 U.S. at 139 (Kennedy, J., concurring in judgment) (defendant's competence "is rudimentary, for upon it depends the main part of those rights deemed essential to a fair trial").

Indeed, where previous precedents, recognizing as fundamental an individual's interest in deciding whether to bear or beget a child, to use contraceptives, or to send a child to private school, have stressed how closely those decisions relate to "personhood," the correspondence between an individual's ideas and mental life and his "identity" and "personality" is understood, in our culture, to be much more direct. To protect the former, but not the latter, would be inconsistent with a commitment to principled exposition of constitutional rights. *See Rochin*, 342 U.S. at 173; *Moore v. East Cleveland*, 431 U.S. 494, 501 (1977) ("Unless we close our eyes to the basic reasons why certain rights * * * have been accorded shelter under the * * * Due Process Clause, we cannot avoid applying the force and rationale of these precedents to the * * * choice involved in this case"); *Poe v. Ullman*, 367 U.S. 497, 543

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described as giving effect to "substantive liberties protected by * * * Fourteenth Amendment" Due Process. *Casey*, 505 U.S. at 847.

(1961) (Harlan, J., dissenting).

These concerns cannot be answered by describing medication as simply "restoring" the individual to his "true self" or by stressing that antipsychotic drugs are intended to (and surely often do) enhance the quantity and coherence of thinking – or suggesting that they operate, with scalpel-like precision, to "clear" only the "sick" thoughts and correct those thinking processes are pathological. But such reassuring metaphors are neither descriptively accurate nor constitutionally satisfactory.[8] *Compare e.g.*, Siegel, et al., 2001 WIS. L. REV. at 349 ("[t]he mechanism of action for [atypical] medications is still not fully known"). Even while suffering mental illness, individuals are capable of expressing important insight, *see, e.g.*, R. PORTER, A SOCIAL HISTORY OF MADNESS: THE WORLD THROUGH THE EYES OF THE INSANE (1987), and even were it possible to untangle thoughts that were "tainted" by illness from those which were not – *see United States v. Brawner*, 471 F.2d 969, 981-83 (D.C. Cir. 1972) (*en banc*) (overruling decision

[8]It has been claimed that the "'[t]he mental health produced by antipsychotic medication is no different from no more inauthentic or alien to the patient than, the physical health produced by other medications, such as penicillin for pneumonia.'" Br. *Amicus Curiae* of Amer. Psychiatric Ass'n, *Riggins v. Nevada*, at 9 (quoted in *id.* at 141 (Kennedy, J., concurring in judgment)). But unlike pneumonia, which is often caused by a known agent (*streptococcus pneumoniae*) and definitively diagnosed through laboratory tests, diagnosis for mental illness is far less exact, and the understanding of etiology is far more speculative. *See* Winick 44 U. MIAMI L. REV. at 49 ("Diagnostic reliability – the probability that two clinicians will agree with each other's diagnosis – is only fifty to sixty percent for schizophrenia"); *see Ake v. Oklahoma*, 470 U.S. 68, 81 (1985) (noting that "psychiatrists disagree widely and frequently on what constitutes mental illness"). As noted above, moreover, antipsychotic drugs do not "cure" the patient, in that their beneficial effects often do not persist beyond their administration and they are generally ineffective against important, "negative" dimensions of the illnesses they are meant to treat.

linking insanity defense to proof that crime was "product" of mental illness) – this Court's cases indicate that even the former would be entitled to solicitude. *Slaton*, 413 U.S. at 67, (the "fantasies of a drug addict are his own and beyond the reach of government'"); *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (First Amendment protects "emotions and * * * sensations," no less than ideas); *cf. Cohen v. California*, 415 U.S. 25, 26 (1971) (abandoning effort to distinguish between "ideational and emotional" speech). Indeed, evidence increasingly supports a more integral relationship between certain highly valued forms of expression and thought processes generally understood to require treatment. *See* K. JAMISON, TOUCHED WITH FIRE: MANIC DEPRESSIVE ILLNESS & THE ARTISTIC TEMPERAMENT (1996) (collecting evidence of association between bipolar disorder and creativity); Winick, 44 U. MIAMI L. REV. at 78 & n. 472 (citing studies finding that some artists refuse medication prescribed for bipolar disorder).

Indeed, the assertion that alteration of the brain is unproblematic because thoughts are shifted in the direction of "normalcy" obscures basic constitutional considerations. The freedom to choose among "better," worse, or more normal versions of oneself is precisely what the Constitution vests in the individual. Thus– without denying the reality of mental illness or the minimizing the pain it causes – there are surely individuals for whom the experiences and thought process of an unmedicated state are, for some reasons, preferable to those experienced after medication. For some individuals, the "sanity" that medication delivers, even if "authentic," *see* n. 9, *supra*, is illegitimate, as a matter of religious scruple, *see Winters v. Miller*, 446 F.2d 65 (2nd Cir. 1971). For others, the effects of the medication – both those which are strictly "cognitive" and those neurological effects that impinge on their efficacy and self-concept do make the medicated state seem "alien" and undesirable.

Finally (and likely least comprehensible) are individuals who affirmatively embrace a condition the world regards as painful and disabling. Although it is tempting to discount any such preference as a manifestation of illness, even within the psychiatric profession, there remains a "distinct minority" who have contended that aspects of schizophrenic thinking are a "'growth experience,'" which can "'open[] new paths of feeling and understanding.'" *See* Winick, U. MIAMI L. REV. at 54 (quoting S. ARIETI, INTERPRETATION OF SCHIZOPHRENIA 121, 378-79 (2d ed.1974)). Although a court required to weigh the available evidence might well decide in favor the majority of the profession, it surely should hesitate before pronouncing impermissible the medication decision of an individual, who poses no danger to others and subscribes, sincerely, to this dissenting "concept of existence [and] meaning." *Casey*, 505 U.S. at 851.

C. That Some Individuals Suffering From Mental Disorders Lack Competency To Make Treatment Decisions Is No Basis For Finding The Autonomy And Integrity Interests Less "Fundamental"

In refusing to apply strict scrutiny, the decision below did not grapple with the distinct constitutional concerns implicated by chemical "mind alteration," or even offer any basis for distinguishing between the autonomy and integrity interests implicated by involuntary injection of antipsychotic drugs and those at stake in other medical treatment situations where liberty interests are undeniably fundamental. *See Rivers*, 495 N.E. 2d at 343 ("if we were dealing here with an ordinary patient suffering from a physical ailment, the hospital authorities would have no right to impose compulsory medical treatment against the patient's will and indeed, that to do so would constitute a common law assault and battery").

Although two conceivably distinguishing features

suggest themselves – that not all persons suffering from mental illness have the capacity to make treatment decisions for themselves and that, historically, courts treated all mentally ill persons as lacking capacity to give (or withhold) consent, *see, e.g.*, *Denny v. Tyler*, 85 Mass. 225, 229 (1861) – neither one supports the Eighth Circuit's choice of less-than-strict scrutiny.

First, as *Cruzan* illustrates, whether a liberty interest is "fundamental" does not depend on whether the individual is personally competent to assert it. Even for individuals whose mental illness does prevent them from making treatment decisions, lack of capacity does not make less real the violation of bodily integrity that forcible medication entails – nor do individuals, by lapsing into incapacity, forfeit their interest in having their religious tenets and personal values respected. *See In re Guardianship of Roe*, 421 N.E.2d 40, 52 (Mass. 1981).

But equally important, the assumption that all individuals suffering from mental illness – or most (or even those ruled incompetent to stand trial) – are incapable of making an informed treatment decision has, as an empirical matter, been discredited:

> Although mental illness sometimes impairs competency to process information and make rational choices, it often does not * * * * Mentally ill people have a significant capacity for normal and rational thought and behavior * * * * Even in the midst of a psychotic episode, mentally ill people function normally some of the time. Moreover, such episodes are intermittent, and between episodes clinicians find it difficult to distinguish with a high degree of certainty "crazy" people from "normal" people.

Winick, *Competency to Consent to Treatment*, 28 HOUS. L. REV. 15, 38-39 (1991); *see* T. Grisso & P. Appelbaum, *The Macarthur Treatment Competence Study, III: Abilities to*

Consent to Psychiatric and Medical Treatment, 19 LAW & HUM. BEHAV. 149, 169-71 (1995) (finding that "on any given measure of decisional abilities, the majority of patients with schizophrenia did not perform more poorly than other patients or nonpatients" and concluding that denial of decisional right "can not be based on the assumption that [such individuals] lack decisional capacity"); Siegel, 2001 WIS. L. REV. at 365 ("Competence to consent to treatment is a functional ability distinct from competence to stand trial, that must be examined separately before involuntary medication to establish competence to stand trial is considered").[9]

These empirical realities have had a powerful effect on the law. It is now standard that individuals are presumed competent, until adjudicated otherwise, and where, traditionally, "an adjudication of incompetency * * * placed [an individual] under total legal disability, * * * [t]he law has moved strongly away from this notion." Winick, 28 HOUS. L. REV. at 23. "Even those who have been involuntarily committed to mental hospitals because they are incompetent to decide about hospitalization are presumed competent to make other decisions," *id.* at 39, and almost every State provides that individuals who are involuntarily committed retain common law and civil rights.[10] *See, e.g., Goedecke v. State Dep't of*

[9]Unlike other disorders, the pathology of delusional disorder often manifests itself in limited realms, *i.e.*, those aspects of the individual's existence that give rise to the delusional material.

[10]*See* Ark. Code Ann. § 20-47-223; Cal. Welf. & Inst. Code § 5331; Colo. Rev. Stat. § 27-10-104; Conn. Gen. Stat. Ann. § 17a-541; D.C. Code Ann. § 21- 564; Fla. Stat. Ann. § 394.459(1); 405 Ill. Comp. Stat. Ann. 5/2-101; Ind. Code Ann. § 12-27-2-3; Iowa Code Ann. § 229.27; Kan. Stat. Ann. 59- 2948(b); La. Rev. Stat. Ann. § 171B; Me. Rev. Stat. Ann. tit. 34-B, § 3803(1); Mass. Gen. Laws Ann. ch. 123, § 24; Mich. Comp. Laws Ann. § 330.1489; Miss. Code Ann. § 41-21-101; Mo. Ann. Stat. § 630.120; Mont.

Insts., 603 P.2d 123, 125 (Colo. 1979) (a "patient's common law right to decline medical treatment is * * * preserved intact[,] in the absence of some finding, reached by a competent tribunal, that the patient's illness has so impaired his judgment that he is incapable of participating in decisions affecting his health"); *Winters* 446 F.2d at 68 ("a finding of 'mental illness' even by a judge or jury, and commitment to a hospital, does not raise even a presumption that the patient is 'incompetent' or unable adequately to manage his own affairs").

And while historic practice is an important guide in describing what is "fundamental," *see Moore*, 431 U.S. at 404, this Court's Due Process cases do not allow – let alone require – that these thoroughly discredited and widely-abandoned suppositions about mental illness live on in constitutional doctrine. On the contrary, this Court, in exercising its responsibility to "to define the liberty of all," *Casey*, 505 U.S. at 850, has refused to give weight to distinctions (even if long-held) that are rooted in misunderstanding or prejudice. Thus, in *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942), the Court refused to countenance a law that denied fundamental liberties to individuals based on "highly technical" distinctions (citing the danger of "unwitting," invidious discrimination), and *Loving v. Virginia*, 388 U.S. 1 (1967), even more squarely

Code Ann. § 53-21-141; Neb. Rev. Stat. §83-1066(1); Nev. Rev. Stat. Ann. § 433A.460; N.H. Rev. Stat. Ann. § 135-C:56(II); N.J. Stat. Ann. § 30:4-24.2(c); N.M. Stat. Ann. § 43-1-5; N.Y. Mental Hyg. Law § 29:03; N.C. Gen. Stat. § 122C-203; N.D. Cent. Code § 25-03.1-33; Ohio Rev. Code Ann. § 5122.301; Okla. Stat. Ann. tit. 43A., § 1-105; Or. Rev. Stat. § 426.295(1); S.C. Code Ann. § 44-17-580(2); Tenn. Code Ann. § 33-3-104(5); Vt. Stat. Ann. tit. 18, § 7706; Va. Code Ann. § 37.1-87; Wash. Rev. Code Ann. § 71.05.450; W. Va. Code § 27-5- 9(a); Wis. Stat. Ann. § 51.59; Wyo. Stat. Ann. § 25-10- 121.

rejected the notion that longstanding practices concerning "interracial" marriage should be incorporated in the definition of that right. *See Casey*, 505 U.S. at 847-48; *id.* at 864 (noting that rationale for *Plessy v. Ferguson* "was so clearly at odds with the facts apparent to the Court [by] 1954 that the decision to reexamine *Plessy* was * * * not only justified but required").

Without requiring that all distinctions based on mental illness be treated as suspect, *see City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432 (1985), this Court's precedents instruct that, where fundamental liberties are involved, conclusory and inaccurate labels may not supply the basis for disparate treatment. *See Skinner*; *but cf. Buck v. Bell*, 274 U.S. 200, 207 (1927) (sustaining involuntary sterilization of an "imbecile," asserting that "[t]he principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes").

D. Involuntary Medication Of Criminal Defendants Warrants Distinct Scrutiny

Although fundamental to any individual, these liberty interests take on distinct importance in the setting giving rise to this case: where government seeks to medicate for the purpose of bringing Petitioner to trial on criminal charges. This forcible drugging occurs at a juncture when his future physical liberty (and not only his bodily and mental integrity) hangs in the balance – and where the Constitution confers a distinct set of special trial rights. U.S. CONST. amends. V, VI.

At the outset, unlike in other instances, where it proceeds as *parens patriae*, with no purpose other than the individual's own well-being, the government here stands as Petitioner's adversary, with the avowed objective of restoring competence, so that he can be tried, convicted, and punished. Thus, while *Riggins* limits drugging to that which is "medically appropriate,"

> [i]t defies reality to describe the process primarily as one * * * to make the defendant well or to make others safe. Either result may occur, but these are distinct from the ultimate legal consequence of enabling the criminal prosecution.

Siegel, 2001 WIS. L. REV. at 358. *See United States v. Gomes*, 289 F.3d 71, 84 (2nd Cir. 2002) ("the government's interest in involuntary medication ceases with the completion of the legal proceedings"); *Ferguson v. Charleston*, 532 U.S. 67 (2001).

In such circumstances, and where (as here) the individual's treating psychiatrists are the government's witnesses, *cf. Estelle v. Smith*, 451 U.S. 454 (1981), the seeming protection offered by requiring findings of "medical appropriateness," "likelihood of restoring competence" and "[that] side effects do not overwhelm benefits" may prove illusory. *See* 282 F.3d at 568-71.

Further, as both the Court's opinion and Justice Kennedy's concurrence in *Riggins* highlight, the rights that are conferred on Petitioner and others as part of the trial process can be compromised in myriad, serious ways by the effects of the drugs the government administers:

> Psychotropic drugs can interfere with a defendant's ability to exercise [trial] rights by causing sedation, producing feelings of restlessness and anxiety, diminishing awareness of and interest in events happening in the surrounding environment, disrupting memory, and inducing all manner of motor disturbances. Administering involuntary psychotropic medications is likely to impair many abilities necessary for presenting a defense, including the ability to pay attention to what witnesses, or the attorneys, or anyone else in the courtroom is saying; to offer comments or suggestions or otherwise engage in a dialogue about the

> trial; to understand and respond to questions while testifying; and even to decide whether to testify. By administering involuntary antipsychotic medications, the government interferes with the defendant's general right to be present, as well as with his more specific rights to receive effective assistance of counsel, to confront witnesses, to present evidence, and to testify on his own behalf.

D. Klein, *Note, Trial Rights and Psychotropic Drugs: the Case Against Administering Involuntary Medications to a Defendant During Trial*, 55 VAND. L. REV. 165, 191 (2002) (quotations and citations to *Riggins* omitted).[11]

[11]Nor is it an answer that diminutions in the accused's ability to participate in the trial proceedings are constitutionally inconsequential – on the ground that his overall "competence" has been restored. Many of the types of trial prejudice identified in *Riggins* are wholly unrelated to the matters decided in a competence inquiry, *see, e.g.*, 504 U.S. at 142 (Kennedy, J., concurring in judgment) (discussing prejudice relating to "defendant's behavior, manner, facial expressions, and emotional responses"). Moreover, that it is constitutionally "fair" to try a minimally competent individual does not establish that the same should be said of a trial where the prosecution (even unintentionally) used its power over the accused to disable him to a point just short of incompetency. *Cf. id.* at 139 (noting connection between forcible medication and evidence manipulation).

II. The Interest In Attempting To Restore Competence To Stand Trial Is Not Compelling

As just noted, unlike medical interventions grounded in *parens patriae* and police powers, the power invoked here – to breach Petitioner's bodily and mental integrity, in order to proceed against him – fits uncomfortably with our tradition of adversarial justice, where individual autonomy is "rudimentary," and the prosecution is required "to shoulder [its] entire load," *Murphy v. Waterfront Comm'n*, 378 U.S. 52, 55 (1964).[12] Accordingly, some courts have questioned whether the government interest relied on below – in "'obtaining an adjudication of [a defendant's] guilt or innocence'" 282 F.3d at 567 (quoting *Riggins*, 504 U.S. at 135) – "could ever be deemed sufficiently compelling to outweigh a criminal defendant's interest." *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984); *see also Rivers* 495 N.E.2d at 343 n.6 (rejecting "[a]ny implication that State interests unrelated to the patient's well-being or those around him can outweigh his fundamental autonomy interest").

Although the question need not be answered here for every conceivable case, *see* 123 S. Ct. 512 (2002) (limiting grant of *certiorari* to whether the Constitution allows

[12]Whether drug-obtained trial participation could be "testimonial" under the Court's Self-Incrimination Clause doctrine, *see Schmerber v. California*, 384 U.S. 757 (1966), the severity and intrusiveness of government action shares much greater affinity with powers denied the prosecution as "conscience-shocking" and "unreasonable," *Rochin*; *Winston*; *cf. Tennessee v. Garner*, 471 U.S. 1, 11 (1985), than with cases where a defendant gives a blood or hair sample.

Nor is Petitioner's situation fairly analogized to that of the defendant in *Illinois v. Allen*, 397 U.S. 337 (1970), who was held to have chosen to absent himself from the proceedings, by wilful refusal to conform his behavior to the court's standards. Petitioner has been given no choice.

medication "to render [Petitioner] competent to stand trial for non-violent offenses"); *see generally* 282 F.3d at 573 (Bye, J., dissenting) (noting that Petitioner's guideline sentence would be in 33 to 41-month range), we submit that "careful," *Reno v. Flores,* 507 U.S. 292, 301 (1993), consideration of the government interest described, in light of this Court's precedents, establishes that it does not rank among those properly recognized as "compelling."[13]

To begin with, government's legitimate interest is not in an adjudication *per se*, but rather in one that is fair and accurate. *Ake*, 470 U.S. at 79 (no legitimate "interest in maintenance of a strategic advantage over the defense, if the result of that advantage is to cast a pall on the accuracy of the verdict obtained"); *Berger v. United States*, 295 U.S. 78, 88 (1935). Even if forcible drugging "succeeds" in rendering Petitioner minimally competent, that same governmental action can undermine – in inexact ways – both fairness and accuracy. *United States v. Brandon*, 158 F.3d 947, 960 (6th Cir. 1998) ("[A] drug that negatively affects [the defendant's] demeanor in court or ability to participate in his own defense will not satisfy the government's goal of a fair trial").

Further, the government interest asserted, although undoubtedly related to the long-acknowledged interest in "preventing and punishing criminality," *United States v. Weston,* 255 F.3d 873, 880 (D.C. Cir. 2001), is more complex and attenuated. Obtaining a conviction of a culpable individual may be of broad societal concern, *see id.* (citing interests in "demonstrating that transgressions of society's prohibitions will be met with an appropriate [punitive] response"), but the

[13]Just as "'Substantive due process' analysis must begin with a careful description of the asserted right," 507 U.S. at 301, similar care is warranted in describing an ostensibly compelling government interest.

constitutionally contemplated alternative "adjudication"– acquittal – implicates wholly different concerns.[14] Putting aside the danger that medication will lead to wrongful conviction, it is jarring to assert that the government has a "compelling interest" in administering medication to an individual, over his objection (potentially causing him lifelong injury by so doing) – so that a verdict of "not guilty" might be rendered. *Cf. Shaw v. Hunt*, 517 U.S. 899 (1996) (rejecting that State "interest in avoiding expense and unpleasantness of litigation * * * *regardless of possible outcome of that litigation*" can be compelling) (emphasis added).

Equally important, denying the government the power to forcibly medicate postpones, but does not necessarily preclude, a later adjudication, and in the intervening time, the government's interest in incapacitation – a significant strand of its police power interest – may be served. *See* 18 U.S.C. § 4246(a). And, accepting the (implausible) assumption that different treatment of the small class of defendants adjudged incompetent and unwilling to take drugs affects the government's broader deterrence interests, it might be noted that Petitioner's lengthy, often solitary, confinement, whether or not "punishment" in the constitutional sense, would surely

[14]Even this formulation – by assuming that medication will result in an adjudication, one way or another – overstates the fit between the interest and the means defended, omitting the possibilities (substantial here) that: competency will not be restored; that "restoration" will be temporary; or that other trial rights will be impaired in such a way that a verdict cannot not be entered. *See Cooper v. Oklahoma*, 517 U.S. 348, 366 (1996) (stressing society's interest in avoiding conviction of an incompetent defendant).

The *Weston* court did not dwell on the prospect that, given the defendant population at issue, many individuals, if "restored" and tried, would both acknowledge "transgressions of society's prohibitions" but, by reason of insanity, avoid any penal "response."

not be without deterrent effect.[15]

Finally, unlike other, more truly compelling interests, the interest in prompt adjudication on the merits is one the government regularly subordinates to other, sometimes mundane objectives. *See Greater New Orleans Broadcasting Ass'n, Inc. v. United States*, 527 U.S. 173 (1999) (evaluating government interest in light of "exemptions and inconsistencies"). Although setting aside a guilty verdict rendered in a proceeding that was fair to the defendant is a rare occurrence, *see, e.g., Powers v. Ohio*, 499 U.S. 400 (1991), the ostensibly "overriding" interests in bringing a case to trial promptly or obtaining full adjudication frequently give way. *See, e.g., North Carolina v. Alford*, 400 U.S. 25 (1970) (plea may be accepted without resolving defendant's factual culpability); *United States v. Ewell*, 383 U.S. 116 (1966) (delay is permissible under Sixth Amendment, because "orderly expedition" is more important than "mere speed"); *see also Doggett v. United States*, 506 U.S. 647, 665 (1992) (Thomas, J., dissenting) (noting competing societal interest in "repose," expressed in ubiquity of statutes of limitations).

Conclusion

For the reasons stated herein, *Amicus* requests that the Court reverse the judgment of the Court of Appeals.

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[15]It also bears mention that disabling government from taking action of this character does not undermine its interest in enforcing a particular law or class of laws. Government efforts to forcibly administer drugs – and individual assertions of constitutional protection – appear, infrequently, in a wide variety of types of criminal case. *Compare Schmerber* (government's power to enforce laws forbidding intoxicated driving dependent on blood test).

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No. 02-5664

IN THE

Supreme Court of the United States

CHARLES THOMAS SELL,

Petitioner,

v.

UNITED STATES OF AMERICA

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

MOTION FOR LEAVE TO FILE BRIEF FOR AMICUS CURIAE AMERICAN PSYCHOLOGICAL ASSOCIATION AND BRIEF FOR AMICUS CURIAE AMERICAN PSYCHOLOGICAL ASSOCIATION

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MOTION FOR LEAVE TO FILE BRIEF FOR AMICUS CURIAE AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association (APA) respectfully moves for leave to file a brief as amicus curiae in this case. Although respondent, the United States, has granted consent to the filing of this brief (and that written consent has been filed with the Clerk of this Court), petitioner has not granted such consent.

The APA is a voluntary nonprofit scientific and professional organization with more than 155,000 members and affiliates. APA has been the principal association of psychologists in the United States since 1892, and includes the vast majority of psychologists holding doctoral degrees from accredited universities in this country. Psychologists have been involved in psychopharmacology and medication issues for many years. APA has two divisions that focus on psychopharmacology—Division 28, Psychopharmacology and Substance Abuse, and Division 55, American Society for the Advancement of Pharmacotherapy—and publishes the peer-reviewed *Journal of Experimental and Clinical Psychophar-*

macology. APA members teach in medical schools and in teaching hospitals. Clinicians who are members of APA assess and treat many individuals who face criminal prosecution, including those who have been found incompetent to stand trial. APA members therefore have substantial expertise and a professional and scientific interest in the appropriate use of antipsychotic drugs and other treatment modalities in that context. APA also has a broader ethical and professional interest in ensuring that persons with mental illness are treated in a humane and beneficial manner.

For the foregoing reasons, the motion for leave to file the brief for amicus curiae American Psychological Association should be granted.

Respectfully submitted.

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IN THE

Supreme Court of the United States

No. 02-5664

CHARLES THOMAS SELL,

Petitioner,

v.

UNITED STATES OF AMERICA

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF FOR AMICUS CURIAE AMERICAN PSYCHOLOGICAL ASSOCIATION

INTEREST OF AMICUS CURIAE

The American Psychological Association (APA) is a voluntary nonprofit scientific and professional organization with more than 155,000 members and affiliates.[1] APA has been the principal association of psychologists in the United States since 1892, and includes the vast majority of psychologists holding doctoral degrees from accredited universities in this country. Psychologists have been involved in psychopharmacology and medication issues for many years. APA has two divisions that focus on psychopharmacology—Division 28, Psychopharmacology and Substance Abuse, and

[1] No counsel for a party authored any part of this brief. No person or entity other than the APA, its members, and its counsel made any monetary contribution towards the preparation or submission of this brief. The written consent of respondent United States to the filing of this brief has been filed with the Clerk of this Court. Petitioner has not provided such consent.

Division 55, American Society for the Advancement of Pharmacotherapy—and publishes the peer-reviewed *Journal of Experimental and Clinical Psychopharmacology*. APA members teach in medical schools and in teaching hospitals. Clinicians who are APA members assess and treat many individuals who face criminal prosecution, including those who have been found incompetent to stand trial. APA members therefore have substantial expertise and a professional and scientific interest in the appropriate use of antipsychotic drugs and other treatment modalities in that context. APA also has a broader ethical and professional interest in ensuring that persons with mental illness are treated in a humane and beneficial manner.[2]

SUMMARY OF ARGUMENT

This case involves a criminal defendant not yet adjudicated of any crime, who has been found incompetent to stand trial, but who has refused to accept treatment with antipsychotic medications that, the government maintains, might restore his trial competence.[3] That defendant has also been determined by the lower courts not to present a danger to himself or others. The government's only justification for administering drugs to him, therefore, is to bring him to trial. Although this case comes to the Court on the assumption that the defendant is charged only with non-violent offenses, the issues reach more broadly, and concern the decision-making process to be employed by a trial court whenever the government seeks to administer such medication to *any* nondangerous defendant who has been found incompetent to stand trial.

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[2] The APA wishes to acknowledge the assistance of Michael F. Enright, Ph.D., Solomon M. Fulero, Ph.D., J.D., Kirk Heilbrun, Ph.D., Rafael Rivas-Vasquez, Psy.D., and Morgan T. Sammons, Ph.D., in the preparation of this brief.

[3] "Antipsychotic" drugs are typically grouped under the broader rubric of "psychotropic" drugs. "Psychotropic medications can include sedatives and tranquilizers . . . , hypnotics . . . , mood stabilizers . . . , antidepressants . . . , [and] antipsychotics. . . ." David M. Siegel et al., *Old Law Meets New Medicine: Revisiting Involuntary Psychotropic Medication of the Criminal Defendant*, 2001 Wis. L. Rev. 307, 345.

A defendant who has been charged with, but has not been convicted of, any offense has at least three profound constitutionally protected interests at stake when the government proposes to undertake the coercive administration of antipsychotic drugs. First, the defendant has an obvious interest, protected as a matter of substantive liberty by the Due Process Clause, in the control of his own body. Second, when powerful drugs affecting brain chemistry are at issue, the defendant also has an interest protected by the First Amendment and the Due Process Clause in his own thought processes. Third, because antipsychotic drugs may affect a defendant's courtroom demeanor and ability to communicate with his attorney, forcible medication may implicate his Fifth and Sixth Amendment trial rights.

In light of the serious intrusion on those weighty interests that accompanies forcible administration of antipsychotic drugs, the trial court should first explore possibilities of less intrusive, non-drug treatment for a particular defendant, and should not order medication unless it is convinced that non-drug therapy alone would be ineffective. In doing so, the court need not force the government to put the defendant through a pointless exercise. If the court is persuaded, based on the testimony of qualified health care professionals, that a particular individual's disorder will not respond to non-drug therapy, the court should proceed to consider the appropriateness of particular medications proposed by the government.

When a trial court concludes that non-drug therapy would not be effective in restoring a particular defendant to competency, the court should not simply assume, however, that coercive administration of drugs *would* be appropriate for that defendant. Antipsychotic drugs can indeed be highly effective and in many cases are medically appropriate. On the other hand, there is a highly significant difference be-

tween the government's purpose in a case like this—coercively restoring a defendant to competence—and the usual situation in which a health-care professional treats a willing patient. Because the individual has a strong interest in avoiding unwanted medications, the trial court should order coercive administration of antipsychotic drugs only if it is persuaded that the specific medications that the government proposes to administer have a substantial likelihood of success in restoring the defendant to competence, and that that likelihood of success clearly outweighs the possible side effects.

In making the determination whether the proposed treatment would be medically appropriate, the trial court must be mindful of the particular characteristics of the defendant's specific disorder and of the medications under consideration, and specifically cannot assume that a medication that is known to be effective for one disorder will likely be effective for another. Many mental disorders that bear some resemblance to one another respond very differently to medication. A court would not be justified in ordering that a defendant with one psychotic disorder be treated with antipsychotic drugs solely because those drugs benefit patients with a different disorder.

The trial court should also carefully consider the side effects of the medication that the government proposes to use. The side effects of some antipsychotic drugs can be very serious, even severe. The advent of "atypical" or second-generation antipsychotic drugs, which are more easily tolerated by most patients and have an apparently lower risk of long-term debilitating side effects, may be pertinent to the trial court's decision, especially now that one such drug has been approved in injectable form. But while the new drugs are an important clinical advance, they are not panaceas. If there is significant disagreement among the professionals as to whether a defendant with a particular disorder will respond to particular medications, or what the side effects of particular medications will be, the court should probe more deeply.

If non-drug therapy is ruled out and drug therapy is thought likely to succeed, the court must nevertheless consider the potential for side effects and do everything it can to minimize or avoid them.

Finally, the court should consider the possibility that antipsychotic drugs may impair the defendant's fair trial rights. Many antipsychotic drugs have the effect of deadening the recipient's reactions, or making him seem restless. This appearance of boredom or restlessness can prejudice the defendant in the eyes of the jury. The drugs can also cloud the defendant's cognition and thus impair his ability to understand the case and communicate with his attorney. If, as trial approaches or at the time of trial, the court concludes that the medication is prejudicing the defendant's fair trial rights, it should decline to order trial of the defendant in his medicated state.[4]

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[4] In addition, in a criminal case involving coercive administration of antipsychotic drugs, there are potentially at least two other significant issues that are not directly presented by this case. First, additional complications may arise when the defendant has been found to be incompetent to refuse medical treatment, as well as incompetent to stand trial. In this case, however, the government has not argued that Dr. Sell is incompetent to make decisions concerning his own health care, and it must therefore be assumed that he competently and rationally decided to refuse antipsychotic drugs. *See Rivers* v. *Katz*, 495 N.E.2d 337, 342-344 (N.Y. 1986) (individuals presumed competent to make medical decisions); *Rogers* v. *Commissioner*, 458 N.E.2d 308, 312-314 (Mass. 1983) (same); Siegel et al., *supra*, at 358-360 (noting that standards for competence to stand trial and competence to make medical decisions are distinct). Although, in some cases, defendants suffering from psychotic disorders who are found incompetent to stand trial may also be found incompetent to make medical decisions, that is less likely to be true in the case of a defendant, such as Dr. Sell, who suffers from delusional disorder. Persons with delusional disorder—unlike, for example, many persons with schizophrenia—often operate a high level of functionality and are "able to maintain employment, . . . to belong to professional or social organizations, [and to] manage [their] daily affairs . . . ." J. Robert Noonan, *Competency to Stand Trial and the Paranoid Spectrum*, 17 Am. J. Forensic Psychol. 5, 11 (1999).

ARGUMENT

The critical starting point in this case is the recognition that the government's interest at issue is not broadly to restore Dr. Sell to mental health, but rather only to restore his competence to stand trial. For that reason, even if a defendant's mental illness interferes with his ability to understand and participate in the proceedings against him, it does not follow that any therapy that might be tried to treat him with his consent in a conventional mental-health setting is justified to restore him to competence. While mental health and competence obviously are related, they are not the same thing.

When, as here, the defendant is a nondangerous pretrial detainee who competently and rationally objects to antipsychotic drugs, the government does not have an undifferentiated interest in treating his mental illness. "Our legal system is premised upon a principle of autonomy for individuals, particularly in making decisions which principally affect their own lives," David M. Siegel et al., *Old Law Meets New Medicine: Revisiting Involuntary Psychotropic Medication of*

Second, the lower courts have reached somewhat differing conclusions on whether the decision on the appropriateness of coercive administration of antipsychotic drugs to a criminal defendant is to be made *de novo* by the trial court hearing the criminal case, or whether the courts should exercise a more deferential standard of review, akin to arbitrary and capricious review under the Administrative Procedure Act, of a decision by government health-care professionals that such administration is appropriate. *See generally* Siegel et al., *supra*, at 334-339. In this case, the district court found (contrary to the Bureau of Prisons) that Dr. Sell was *not* dangerous to himself or others, *see* Pet. App. 37-40, and then apparently exercised *de novo* review over the question whether forcible medication was appropriate solely for the purpose of restoring him to competency to stand trial, *see* Pet. App. 4 (noting that the magistrate "conducted a full judicial hearing" on the issue). The government did not argue that a more lenient standard of review was appropriate. *See* Gov't C.A. Br. 22 n.6. Accordingly, while the APA is of the view that a *de novo* judicial determination is required, the Court need not decide that question in this case.

the Criminal Defendant, 2001 Wis. L. Rev. 307, 357, and the government does not have a broad *parens patriae* power that permits it to take whatever steps are necessary (coercively, if need be) to restore someone's mental health. Thus, the question the trial court must consider is not (as a patient might consider for herself) whether a particular course of treatment *might* be effective, but rather whether the government's narrow interest in attaining competence justifies the serious intrusions involved in coercive administration of antipsychotic drugs.

A. In a Case Involving a Defendant Who Is Not Competent To Stand Trial, a Court Should First Consider Whether Any Non-Drug Therapy Could Restore The Defendant To Competence

1. Competence to stand trial is a legal standard expressed in functional terms. A defendant is competent to stand trial when he demonstrates "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding," as well as "a rational as well as factual understanding of the proceedings against him." *Dusky* v. *United States*, 362 U.S. 402, 402 (1960) (per curiam). In some circumstances, when an individual's trial incompetence is a product of mental illness, antipsychotic drugs may be effective in alleviating the symptoms of the disorder, and thereby help the defendant become competent. Antipsychotic drugs achieve these results by "alter[ing] the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes." *Washington* v. *Harper*, 494 U.S. 210, 229 (1990).

When a defendant competently and rationally refuses to accept antipsychotic drugs, however, at least three weighty, constitutionally protected interests of the individual are at stake. *First*, the individual has a right, firmly rooted in the common law and protected as a matter of substantive liberty by the Due Process Clauses of the Fifth and Fourteenth

Amendments, to "determine what shall be done with his own body." *Schloendorff* v. *Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.); *see Ingraham* v. *Wright*, 430 U.S. 651, 673 (1977) (noting that "[a]mong the historic liberties" protected at common law was the freedom against "unjustified intrusions on personal security") (quoting 1 W. Blackstone, *Commentaries* * 134)). That right is surely one of the fundamental personal rights that is "implicit in the concept of ordered liberty." *Palko* v. *Connecticut*, 302 U.S. 319, 325 (1937) (Cardozo, J.) (internal quotation omitted). As the Court has recognized, "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." *Harper*, 494 U.S. at 1229; *see Riggins* v. *Nevada*, 504 U.S. 127, 134 (1992); *see also United States* v. *Brandon*, 158 F.3d 947, 953 (6th Cir. 1998) ("[F]orced medication implicates [a] Fifth Amendment liberty interest in being free from bodily intrusion").

Second, the defendant's interest in avoiding forcible administration of antipsychotic drugs is particularly weighty because (a) those drugs in many cases have quite serious side effects, and (b) they operate on the individual's thought processes, and thus implicate fundamental issues of personhood and individuality, beyond those that might be implicated by compulsory introduction of other medications (such as vaccinations or sedatives). We address the side effects of antipsychotic drugs in greater detail below (*see* pp. 20-25, *infra*), but for present purposes it bears emphasis that such drugs are "often accompanied by toxic reactions and adverse side effects, some of which are quite serious and irreversible." Bruce J. Winick, *The Right to Refuse Medical Treatment* 72 (1997); *see* Rafael A. Rivas-Vazquez et al., *Atypical Antipsychotic Medications: Pharmacological Profiles and Psychological Implications*, 31 Prof. Psychol. Res. & Prac. 628, 629-630, 633-635 (2000). The side effects of antipsychotic

drugs are well documented in the scientific literature[5] and have often been recognized by the courts.[6]

Moreover, because antipsychotic drugs operate on the functioning of the brain, their coercive use by the government implicates basic liberties of thought and conscience protected by the First and Fourteenth Amendments. *Cf. Palko*, 320 U.S. at 326-327 ("[F]reedom of thought . . . is the matrix, the indispensable condition, of nearly every other form of freedom. With rare aberrations a pervasive recognition of that truth can be traced in our history, political and legal."); *West Va. State Bd. of Educ.* v. *Barnette*, 319 U.S. 624, 642 (1943) (identifying a "sphere of intellect and spirit which it is the purpose of the First Amendment to our Constitution to reserve from official control"); *Stanley* v. *Georgia*, 394 U.S. 557, 565 (1969) ("Our whole Constitutional heritage rebels at the thought of giving government the power to control men's minds."). Although this Court has not precisely identified the nature of an individual's interest in refusing to take antipsychotic drugs, as compared with refusing other forms of medication, given those drugs' powerful effects on cognition, and thus on the individual's very personhood, their forcible administration implicates the First Amendment as well as the Due Process Clauses of the Fifth and Fourteenth Amendments.

Third, antipsychotic medication may adversely affect the defendant's fair trial rights under the Fifth and Sixth Amendments. The first set of risks involves well-known side

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[5] *See, e.g.*, Rivas-Vazquez et al., *supra*, at 629-630; Philip G. Janicak et al., *Principles and Practice of Psychopharmacology* 188-217; *Drug-Induced Dysfunction in Psychiatry* 107-168 (Matcheri S. Keshavan & John S. Kennedy eds., 1992).

[6] *See, e.g.*, *Riggins*, 504 U.S. at 134; *id.* at 142-144 (Kennedy, J., concurring); *Harper*, 494 U.S. at 229-230; *Mills* v. *Rogers*, 457 U.S. 291, 293 n.1 (1982); *United States* v. *Weston*, 255 F.3d 873, 877 n.3 (D.C. Cir. 2001); *Kulas* v. *Valdez*, 159 F.3d 453, 455-456 (9th Cir. 1998), *cert. denied*, 528 U.S. 1167 (2000); *United States* v. *Brandon*, 158 F.3d 947, 954 (6th Cir. 1998).

effects associated with certain antipsychotic drugs: they can alter the individual's demeanor "in a manner that will prejudice his reactions and presentation in the courtroom," such that he will appear unsympathetic to the jury or even the judge. *Riggins*, 504 U.S. at 142 (Kennedy, J., concurring). Some antipsychotic drugs can "flatten or deaden [the recipient's] emotional responses," *United States* v. *Weston*, 206 F.3d 9, 20 (D.C. Cir. 2000) (Tatel, J., concurring), making him look "so calm or sedated as to appear bored, cold, unfeeling, and unresponsive," *Riggins*, 504 U.S. at 143 (Kennedy, J., concurring) (quotation marks omitted). In other cases, restlessness, Parkinsonian tremors, muscle spasms, and slurred speech may adversely affect the jury's opinion of a defendant. *See id.* at 142-143 (Kennedy, J., concurring). *See generally* Siegel et al., *supra*, at 324-325, 346-347 (surveying these side effects). It is particularly important for a court to be attentive to these potential side effects, because they may be overlooked by health-care professionals—to whom they may seem of minimal significance when compared to the more dramatic symptoms of active psychosis—and yet they may have a profound effect on the jury's evaluation of the defendant. *See id.* at 330 & n.122. In addition, antipsychotic drugs may dull the defendant's cognition, thus compromising his "interaction with counsel, or his comprehension at trial." *Riggins*, 504 U.S. at 138.

2. In light of these weighty, constitutionally protected individual interests, a court should not order involuntary administration of medication to restore a defendant to competence without first exploring less intrusive, non-drug-based methods of treatment. The court should first require the government to demonstrate, by clear and convincing evidence, the absence of any non-drug therapies that would be effective in restoring competence. Moreover, "[w]here the expert testimony does not clearly eliminate the possibility that other [non-drug] approaches may be efficacious, . . . they should be attempted in an effort to determine whether medication is

truly necessary to maintain the defendant's competency." Winick, *supra*, at 322.

There is no question that antipsychotic drugs are often greatly beneficial for patients with mental disorders. Precisely because of that fact, however, certain health-care professionals have a well-documented tendency to overprescribe drugs and disregard other, less intrusive modalities of treatment that may also be beneficial. *See generally* Winick, *supra*, at 76-85.[7] There is a significant danger, therefore, that health-care professionals in a forensic setting may proceed immediately to medication without considering less intrusive alternatives that might be effective in restoring competence.[8] In fact, behavioral and psychosocial therapies can be effective in treating certain aspects of psychosis, such as aggres-

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[7] There is also a danger that clinicians may overlook a diagnosis which would suggest that the patient's disorder would be responsive to non-drug therapy. *See* Theo C. Manschreck, *Delusional Disorder and Shared Psychotic Disorder*, in 1 Benjamin J. Sadock and Virginia A. Sadock, eds., *Comprehensive Textbook of Psychiatry* 1243, 1259 (7th ed. 2000) (cautioning that the clinician "should avoid the temptation to make the diagnosis of schizophrenia and delusional disorder"—which are often thought to be resistant to non-drug therapy—"prematurely in cases where paranoid features are present, as those features occur regularly in a variety of psychiatric and medical illnesses"); *id.* at 1260 (discussing difference between delusional disorders and mood disorders with psychotic features, such as depressions in which a patient may have delusions that are congruent with his mood).

[8] One scholar has noted that "[t]reatment for incompetence to stand trial in most forensic hospitals often differs little from treatment provided for mentally ill patients who are civilly committed, even though one can argue that there should be a difference in objectives when treating these two populations." Thomas Grisso, *Five-Year Research Update (1986-1990): Evaluations for Competence to Stand Trial*, 10 Behavioral Sci. & L. 353, 364 (1992); *see also* Alex M. Siegel & Amiram Elwork, *Treating Incompetence to Stand Trial*, 14 L. & Human Behavior 57, 58 (1990) (57% of forensic directors responding to a survey reported that they do not treat patients who are adjudicated incompetent any differently than other patients).

sive behavior.[9] Although such therapies are often not adequate by themselves to treat acute psychotic disorders, they may be particularly effective even for psychosis when employed along with antipsychotic drugs. *See generally* Glen O. Gabbard, *Combined Psychotherapy and Pharmacotherapy*, in 2 Benjamin J. Sadock & Virginia A. Sadock, eds., *Comprehensive Textbook of Psychiatry* 2226-2227 (7th ed. 2000). In a combined approach, moreover, lower drug doses can often be used and the course of drug therapy can often be shortened. *See* Winick, *supra*, at 322; Rivas-Vazquez et al., *supra*, at 637.

Consideration of non-drug therapies is particularly important where, as here, the specific therapeutic goal is helping an individual develop or recover functional abilities, such as assisting his attorney during a criminal trial. Trial incompetence and mental disability are not the same thing, although they are related and may overlap. *See* Siegel & Elwork, *supra*, at 58. For some individuals, the presence of psychosis does not necessarily mean the absence of the necessary understanding of the fundamentals of a criminal trial. *See* J. Robert Noonan, *Competency to Stand Trial and the Paranoid Spectrum*, 17 Am. J. Forensic Psych. 5 , 17 (1999); Robert A. Nicholson & Karen E. Kugler, *Competent and Incompetent Criminal Defendants: A Quantitative Review of*

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[9] *See* V. Lehtinen et al., *Two-Year Outcome in First-Episode Psychosis Treated According to an Integrated Model: Is Immediate Neuroleptisation Always Needed?*, 15 European Psychiatry 312, 318 (2000) (reporting study in which psychotic patients who were treated with intensive psychosocial interventions combined with no or minimal use of medications had results at least as good as those whose treatment regime included the usual doses of medications); Grisso, *supra*, at 365 (noting that one study had yielded the finding that "incompetent defendants who refused medication had a higher rate of restoration of competence" than those who had accepted antipsychotic medication); *see also* Shirley M. Glynn et al., *Compliance With Less Restrictive Aggression-Control Procedures*, 40 Hosp. & Comm. Psychiatry 82 (1989) (study demonstrated usefulness of non-restraint-based "time out" procedures to curb aggression in psychotic patients).

Comparative Research, 109 Psychol. Bull. 355, 356 (1991). Conversely, alleviating psychosis in individuals who lack those functional abilities does not necessarily restore them. Indeed, antipsychotic drugs are not designed to *develop* abilities and skills at all; rather, they are intended to suppress symptoms of certain mental disorders. Thus, determining the appropriate treatment (if any) for attempting to restore a defendant's competence to stand trial must take account of treatments designed specifically to address trial incompetence. It is here that psychological approaches, including psychosocial and psychoeducational therapies, may be most useful. Because these kinds of treatment can be designed specifically to address trial incompetence, they may be able to achieve targeted results better than antipsychotic medication alone.[10]

For individuals with some diagnoses, however—including delusional disorder—particular features of the disorder may present considerable obstacles to the effectiveness of non-drug therapy. An individual (such as Dr. Sell) with delusional disorder, persecutory type who is committed to a forensic hospital may be inelined to conclude that his therapist is part of a conspiracy against him. Treatment involving only non-drug psychotherapy may not be capable of shaking this belief, and thus may be unlikely to assist him in gaining a realistic understanding of the trial process and the role of his attorney and the judge, prosecutor, and jury—especially if the individual already is convinced that actors in the judicial process are participating in a conspiracy against him.[11] In

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[10] *See* Kirk Heilbrun et al., *The Debate on Treating Individuals Incompetent for Execution*, 149 Am. J. Psychiatry 596, 602 (1992) ("The connection between [psychosocial rehabilitation] and competency-relevant behavior seems potentially strong."). The scientific literature includes discussions of innovative and evidently successful psychosocial and psychoeducational therapies for defendants found incompetent to stand trial. *See* Grisso, *supra*, at 364; Siegel & Elwork, *supra*, at 60.

[11] Because delusional disorders are uncommon, the effectiveness of cognitive and behavioral therapies for those disorders has thus far been

some cases, therefore, a trial court may conclude, based on the professional judgment of health-care professionals who have examined an incompetent defendant, that non-drug therapy would not be effective for that person. If the court is persuaded to that effect, then the government and the individual should not be compelled to go through a pointless exercise.

B. The Trial Court Must Also Determine That The Proposed Medication Would Have A Substantial Likelihood Of Success In Restoring The Defendant To Competence, And That Its Effectiveness Clearly Outweighs The Risk From Side Effects

Even if a trial court determines that non-drug therapy would not restore a defendant to competence, it does not necessarily follow that the court would be justified in ordering administration of antipsychotic drugs. A willing patient and her therapist might well agree to try a particular medication even if its likelihood of success is far from certain and even if the side effects might be serious, and then might shift to a different medication if the first one is not effective or yields unacceptable side effects. But in the case of an individual who has competently refused medical treatment, an open-ended trial-and-error approach is inappropriate. To justify the serious intrusion onto personal autonomy that accompanies coercive administration of antipsychotic drugs, greater

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little studied. *See* Manschreck, *supra*, at 1262. Although such therapies have been described as "promising," *ibid.*, the currently prevailing view is that persons with delusional disorder tend to be "refractory to attempts to reduce their delusional thinking," *id.* at 1263. *See* Noonan, *supra*, at 12 (persons with delusional disorder are "typically not responsive to persuasion or offers of treatment, . . . [and] construe offers to medicate as yet another facet of the devious conspiracy to deprive one of his rights and do him in"); S.P. Garcelan et al., *Effectiveness of Individual Cognitive-Behavioural Therapy Applied to Psychotic Symptoms*, 4 Psychology in Spain 3, 10 (2000) (concluding that cognitive and behavioral therapy alone is unlikely to be successful for persons with delusional disorders).

assurance is necessary about any particular medication that the government proposes to be use, and serious risk must be avoided.

Before ordering a medication to be forcibly administered, a trial court must conclude that there is a substantial likelihood that the particular medication or medications to be used will be effective at restoring the individual to competence, and that the medication's benefits clearly outweigh its adverse side effects, including the possible effects on the individual's fair trial rights. *See Riggins*, 504 U.S. at 135 (finding forcible administration of antipsychotic drugs "impermissible absent a . . . determination of medical appropriateness"). There will likely be many cases (particularly those involving well-studied disorders in which the effectiveness of medication has been well documented) in which a trial court can conclude that antipsychotic medication is medically appropriate. But there may well be others (possibly including cases like this one, involving a defendant diagnosed with delusional disorder) in which the court cannot conclude that any medication has been shown with sufficient assurance to be effective with respect to a particular defendant to justify the intrusion, or that the anticipated side effects are too serious—either as an absolute matter or when compared to the anticipated benefits—to justify forcible administration. In such a situation, the court should decline to order administration of drugs, even if no non-drug therapy would likely be effective. In the case of a nondangerous individual who has not been convicted of any crime, the personal interest in autonomy is too weighty to justify intrusive administration of antipsychotic medications with speculative benefits or grave side effects.

1. Ascertaining Whether Medication Would Be Effective

a. Antipsychotic drugs are often effective in alleviating the psychotic symptoms of mental disorders. *See* Philip Janicak et al., *Principles and Practice of Psychopharmaco-*

therapy 110-133 (2d ed. 1997). Nevertheless, a substantial minority of patients do not benefit from such drugs. Winick, *supra*, at 70. For example, not all persons with mental impairments affecting competence have conditions that will respond to such drugs. For some persons, the point is obvious: no one would expect a defendant who is mentally retarded, for example, to attain competence because he has received antipsychotics.

The point is true as well for individuals with psychotic disorders, because different psychotic disorders respond differently to medication. Many judges, for example, may be generally aware of paranoid schizophrenia and may have the impression that it responds favorably to antipsychotic drugs. But paranoid schizophrenia is only one of several distinct disorders that have a passing resemblance to one another. *See* Noonan, *supra*, at 7; American Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 299-300, 313-314, 323-324, 327 (4th ed. text rev. 2000) ("DSM-IV-TR").

Dr. Sell, for example, has been diagnosed with delusional disorder, persecutory type. Pet. App. 3. This disorder is uncommon, and has paranoid features distinct from those of paranoid schizophrenia.[12] Individuals with paranoid schizophrenia suffer from auditory hallucinations and bizarre delusions that are "unable to be understood from the perspective of normal human experience." Noonan, *supra*, at 7; *see also id.* at 8-9; DSM-IV-TR, *supra*, at 313-314. By contrast, although persons with delusional disorder occasionally suffer from "simple hallucinations," that is not the principal feature of the illness. *See* Theo C. Manschreck, *Delusional Disorder and Shared Psychotic Disorder*, in 1 Benjamin J. Sadock and

[12] One source states that delusional disorder has a prevalence of 0.03%. Schizophrenia, by contrast, has a lifetime prevalence of one percent. *See* Rhoda K. Hahn et al., *Current Clinical Strategies: Psychiatry* 16, 21 (2003-2004 ed.), *available at* http://www.medical-library.org/library/secure/Psychiatry.pdf.

Virginia A. Sadock, eds., *Comprehensive Textbook of Psychiatry* 1254 (7th ed. 2000). Rather, persons with delusional disorder, persecutory type, usually entertain deep-seated convictions that they are the subject of "vast, surreptitious plot[s]" to do them harm. Noonan, *supra*, at 11; *see also* Manschreck, *supra*, at 1243, 1246-1247, 1254-1255; DSM-IV-TR, *supra*, at 325. Moreover, unlike schizophrenics, persons with delusional disorder usually do *not* manifest otherwise disturbed thought processes. Indeed, they are often superficially well functioning, and can maintain employment and a family life. *Id.* at 324; Noonan, *supra*, at 11; Manschreck, *supra*, at 1254.[13]

At present, there is no consensus among researchers that delusional disorder, persecutory type will respond favorably to antipsychotic drugs, in part because of the lack of controlled studies.[14] If an individual with delusional disorder

[13] Although there is increasing awareness of the distinctiveness of delusional disorders, "clinicians are relatively ill-informed about delusional disorders and may have only seen an occasional example." Manschreck, *supra*, at 1243; *see id.* at 1244 (noting that "[m]any clinicians remember being taught that [delusional disorder] is so rare that most would not see a single such patient during an entire career"); *id.* at 1250 (stressing need for increased understanding of delusional disorder as distinct condition from schizophrenia).

[14] *See* Alan A. Felthous et al., *Are Persecutory Delusions Amenable To Treatment?*, 29 J. Am. Acad. Psych. L. 461, 461, 465 (2001) (noting "common assumption that pure persecutory delusions are hopelessly resistant to treatment," observing that "[t]here have been no controlled studies of specific agents in the treatment of delusional disorders," but concluding that "what little exists in the way of studies yields results that are not entirely hopeless"); Hernan Silva et al., *Effects of Pimozide on the Psychopathology of Delusional Disorder*, 22 Prog. Neuro-Psychopharmacol. & Biol. Psychiatry 331 (1998) (concluding that pimozide is ineffective in treating delusional disorder); Hahn et al., *supra*, at 22 (stating that delusional disorders are "often refractory to antipsychotic medication"); *see also* Manschreck, *supra*, at 1262 ("Because controlled studies are limited and the disorder is uncommon, the results required to support [treatment with antipsychotic medication] empirically have been only partially obtained.").

sought treatment voluntarily, a therapist might be justified in trying a variety of medications that have been shown to be effective with other psychotic conditions, based on the "natural presumption" (Manschreck, *supra*, at 1263) that those medications would be effective for other psychoses as well. But given the important autonomy interests at stake in the case of an individual who has competently refused antipsychotic drugs, a court would not be justified in indulging such a presumption without greater evidence that the individual's specific condition will respond to the particular proposed medication.

b. A second difficulty with antipsychotic drugs is that they may do little to address cognitive and social impairments that are so-called "negative" symptoms of some psychotic disorders, such as loss of motivation, poverty of speech, and attention deficit.[15] *See* David G. Cunningham Owens, *Adverse Effects of Antipsychotic Agents: Do Newer Agents Offer Advantages?*, 51 Drugs 895, 899 (1996) (noting a "glaring lack of professional consensus on the point" and stating that "it is hard to be sanguine" about the usefulness of medications for negative symptoms); David L. Penn et al., *Research Update on the Psychosocial Treatment of Schizophrenia*, 153 Am. J. Psychiatry 607, 607 (1996) ("[A]lthough pharmacotherapy is effective for treating acute symptoms . . . it does not alleviate residual cognitive and social deficits . . . ."). These "negative" symptoms, however, may significantly impair a defendant's competence to stand trial, and if the antipsychotic medication that the government proposes to administer cannot address them, then the usefulness of the medication may be doubtful. *See* Stephen G. Noffsinger, *Restoration to Competency Practice Guidelines*, 45 Int'l J. Offender Therapy & Comparative Criminology 356, 357 (2001) (noting that "[p]ersons with schizophrenia may have

[15] Symptoms of psychotic disorders are often categorized as "positive" or "negative." Positive symptoms include hallucinations and delusions. *See* DSM-IV-TR, *supra*, at 299-300.

cognitive impairment accompanying their psychotic symptoms, which may impair the educational component of competency restoration"). Thus, a trial court should pay careful attention to the presence of such negative symptoms and should examine whether there is a substantial likelihood that those symptoms, too, will be addressed. In some cases, the court may conclude that a combined approach of psychotherapy and medication (possibly with lower dosage) would effectively address the totality of symptoms, including negative symptoms, that impair a defendant's competence to stand trial. *See* Penn, *supra*; pp. 12-13, *supra*.

c. In light of the serious intrusion involved in compulsory administration of antipsychotic medication, more should be required than merely a showing that no *less* intrusive approach would be effective. In addition, the government should be required to demonstrate that a particular medication is substantially likely to be effective. If the government cannot make that showing, then administration of drugs should not be ordered.

It is possible that in some cases, a trial court could not confidently conclude that an individual would respond to either drug or non-drug therapy. Conceivably, in those cases, the defendants could not be brought to trial. Fortunately, there is reason to believe that such cases are uncommon. Studies have concluded that the vast majority of incompetent defendants who are involuntarily committed for treatment are successfully restored to competence.[16] Of those who cannot

[16] *See* Brian Ladds et al., *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review*, 21 Bull. Am. Acad. Psychiatry L. 529, 541 (1993) (more than 87% restored to competence); Brian Ladds & Antonio Convit, *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Review of Empirical Studies*, 22 Bull. Am. Acad. Psychiatry L. 519, 530 (1994); Robert A. Nicholson et al., *Predicting Treatment Outcome for Incompetent Defendants*, 22 Bull. Am. Acad. Psychiatry L. 367, 368, 371 (1994); Robert A. Nicholson & John L. McNulty, *Outcome*

be restored to competence, a significant number may well present a danger to themselves or others and thus would be proper subjects for civil commitment. *Cf. Riggins*, 504 U.S. at 145 (Kennedy, J., concurring).

2. Assessing The Side Effects Of Antipsychotic Drugs

Antipsychotic drugs may be divided into two general categories: older "conventional" drugs, and the more recently developed "atypical" drugs.[17] Although both classes of drugs are often effective in treating many psychotic disorders, they both also carry risks of a range of side effects. Common side effects of conventional antipsychotic drugs include "extrapyramidal" reactions, a family of disorders including Parkinsonism, akathisia, dystonia, and (most serious of all) tardive dyskinesia.[18] Extrapyramidal reactions occur in at

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of Hospitalization for Defendants Found Incompetent to Stand Trial, 10 Behav. Sci. & L. 371, 376, 380 (1992).

[17] Conventional antipsychotic drugs include, among others, haloperidol (Haldol), thiothixene (Navane), chlorpromazine (Thorazine), and thioridazine (Mellaril). Atypical drugs include clozapine (Clozaril), risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), and ziprasidone (Geodon). *See Physician's Desk Reference* (54th ed. 2000), at 2153-57 (Haldol), 2356-58 (Navane), 3050-52 (Thorazine), 1973-74 (thioridazine), 2008-2013 (Clozaril), 1453-57 (Risperdal), 1649-53 (Zyprexa), 562-66 (Seroquel).

[18] *See* Thomas R.E. Barnes & J. Guy Edwards, *The Side-Effects of Antipsychotic Drugs. I. CNS and Neuromuscular Effects*, in *Antipsychotic Drugs and Their Side-Effects* 213, 217 (1993). Parkinsonism resembles the symptoms of Parkinson's disease, and consists of muscular rigidity, resting tremors, motor retardation, a mask-like face, and pill-rolling hand movements. *Id.* at 214. Akathisia is a feeling of restlessness and a need to be in constant motion, causing the patient to pace and tap his foot incessantly. *Id.* at 223. Dystonia involves severe spasms of the head and neck muscles often accompanied by facial grimacing, involuntary spasms of the tongue and mouth, oculogyric spasms (which involve a brief, fixed stare, followed by the eyes rolling upward for minutes at a time), bizarre posture and gait, and violent movement of the arms. *Id.* at 219. Tardive dyskinesia is a "particularly pernicious" extrapyramidal reaction characterized by "involuntary, rapid, and jerky movements of facial and oral

least 50% to 75% of patients treated with conventional antipsychotic drugs; some estimates are as high as 90%. *See* Rivas-Vazquez et al., *supra*, at 630.[19] These extrapyramidal symptoms can be "subjectively quite stressful, may be incompatible with clinical improvement and with a useful life outside the hospital, and can be more unbearable than the symptoms for which the patient was originally treated." Winick, *supra*, at 73. Conventional antipsychotics frequently produce other unpleasant side effects as well, including sedation, interference with concentration, blurred vision, dry mouth and throat, constipation, urine retention, orthostatic hypotension (low blood pressure when standing), tachycardia (rapid beating of the heart), weakness, and dizziness. *See* Janicak et al., *supra*, at 201-203.[20]

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muscles, upper and lower extremities, and the trunk." Rivas-Vazquez, *supra*, at 630; *see* Barnes & Edwards, *supra*, at 228-229. As a "tardive" condition, it tends to occur after prolonged administration of an antipsychotic drug, and may not even become evident until after the drug treatment has stopped. *See* Paul S. Appelbaum, *Almost a Revolution* 116 (1994); James B. Lohr, *Tardive Dyskinesia*, in *Drug-Induced Dysfunction in Psychiatry* 131 (Matcheri S. Keshavan & John S. Kennedy eds., 1992). Once the condition develops, it is "potentially irreversible," Rivas-Vazquez, *supra*, at 630, and in any event "may persist long after discontinuation of the antipsychotics" that caused it. *See* Lohr, *supra*, at 131.

[19] This Court has observed that "the proportion of patients treated with [conventional] antipsychotic drugs who exhibit the symptoms of tardive dyskinesia ranges from 10% to 25%." *Harper*, 494 U.S. at 230. The incidence of tardive dyskinesia in older patients is much higher. *See generally* J.M. Kane, *Tardive Dyskinesia: Epidemiology and Clinical Presentation*, in *Psychopharmacology: The 4th Generation of Progress* 1485-1495 (F.E. Bloom & D.J. Kupfer eds., 1995).

[20] Conventional antipsychotics can also cause a potentially fatal disorder known as "neuroleptic malignant syndrome." Gerard Addonizio, *Neuroleptic Malignant Syndrome*, in *Drug-Induced Dysfunction in Psychiatry* 145, 145 (Matcheri S. Keshavan & John S. Kennedy eds., 1992). If untreated, this relatively rare (but underdiagnosed) condition can lead to potentially fatal respiratory failure, cardiovascular collapse, and acute kidney failure. *See* Winick, *supra*, at 74 & n.72.

The newer, "atypical" antipsychotics, which have been determined to be effective in treating some psychotic disorders, are reported to have a more favorable side effect profile than the older conventional drugs. *See* Rivas-Vazquez et al., *supra*, at 628; Alan A. Felthous et al., *Are Persecutory Delusions Amenable To Treatment?*, 29 J. Am. Acad. Psychiatry L. 461, 463 (2001).[21] Each of these drugs, however, can also cause potentially serious side effects. Clozapine, described as "the 'gold standard' for atypical agents," Rivas-Vazquez et al., *supra*, at 634, presents a risk of agranulocytosis, a potentially fatal disappearance of white blood cells, as well as numerous other disabling side effects. *See* Janicak et al., *supra*, at 206-207.[22] Risperidone and olanzapine both carry a risk of extrapyramidal effects, particularly when used in elevated dosages, *id.* at 192-194, and quetiapine can cause cataracts. *See* Rivas-Vazquez, *supra*, at 634-635. Ziprasidone, an atypical drug recently approved by the Food and Drug Administration (FDA) for the treatment of schizophrenia, has a generally favorable side effect profile, but it has been

[21] It remains unclear, however, whether the newer drugs are more effective than the older, conventional agents in treating symptoms of psychosis. One recent study has concluded that aytpical drugs, as a class, produce no greater benefits in treating psychotic disorders than conventional drugs and also have no greater benefits in overall tolerability, although they do cause fewer extrapyramidal side effects. *See* John Geddes et al., *Atypical Antipsychotics in the Treatment of Schizophrenia: Systematic Overview and Meta-Regression Analysis*, 321 British Med. J. 1371, 1371 (2000). Moreover, that study suggests that the reported more favorable side effect profile of atypical drugs may actually result from the use of higher than recommended doses of conventional drugs in some clinical trials. *See id.* at 1374; Cunningham Owens, *supra*, at 902 (same).

[22] Evidence suggests that agranulocytosis occurs in 2% of patients receiving clozapine. *See* Robert M. Wettstein, *Legal Aspects of Prescribing*, in *Drug-Induced Dysfunction in Psychiatry* 9, 16 (Matcheri S. Keshavan & John S. Kennedy eds., 1992). It is possible to monitor patients for this syndrome and to discontinue administration of the drug before the condition becomes too grave, but such monitoring is a demanding process, requiring weekly or even twice weekly blood tests for the initial six months of treatment. *See* Janicak et al., *supra*, at 206.

linked to a potentially serious heart-rhythm irregularity, and the manufacturer has recommended against its use by patients with cardiac arrhythmia.[23] Atypical agents can also cause other side effects such as sedation, seizures, hypotension, and weight gain. Rivas-Vazquez, *supra*, at 633-635. Moreover, because atypical antipsychotic drugs have been in widespread use for only a short time, it is possible that they may also cause some late-onset side effects that have not yet been reliably identified, but that may appear in the future.

Until very recently (and when this case was decided in the lower courts), atypical drugs had been approved only for oral administration, and only conventional drugs could be administered in injectable form.[24] As a practical matter, therefore, when patients have been unwilling to accept antipsychotic medication, the only alternative has been to administer conventional drugs, with their more serious side effects, by injection. Many patients who have experience with the mental-health system and who have taken conventional antipsychotic drugs have found the side effects of those drugs to be unacceptable. Indeed, side effects constitute a principal reason why many patients stop taking antipsychotic drugs. *See* Winick, *supra*, at 73 n.67; Rivas-Vazquez et al., *supra*, at

[23] *See* Alexander H. Glassman and J. Thomas Bigger, Jr., *Antipsychotic Drugs: Prolonged QTc Interval, Torsade de Pointes, and Sudden Death*, 158 Am. J. Psychiatry 1774, 1778 (2001) (observing that "[a]lthough it is reassuring that ziprasidone was not associated with cardiac events during premarketing trials, that is not sufficient to guarantee that uncommon but life-threatening arrhythmias will not occur once the drug is in widespread use"); FDA, *Medwatch: The FDA Safety Information and Adverse Event Reporting System, 2002 Safety Alert—Geodon (ziprasidone HCl), available at* www.fda.gov / medwatch / SAFETY / 2002 / gedon.htm; Pfizer, Inc., *Geodon, available at* www.pfizer.com /download/geodon.pdf. The potential for cardiac complications from ziprasidone are likely to be of particular concern for somewhat older persons, such as Dr. Sell.

[24] *See* Paul A. Nidich & Jacqueline Collins, *Involuntary Administration of Psychotropic Medication: A Federal Court Update*, 11 No. 4 Health Law. 12, 13 n.21 (1999); *Weston*, 255 F.3d at 886 n.7.

630. In this case, for example, Dr. Sell explained his resistance to medication by stating that he had previously taken Haldol but had found the side effects to be intolerable. Pet. C.A. Br. 5; *see also* Felthous et al., *supra*, at 463 (noting that "paranoid patients are usually very sensitive to all side effects of drugs") (citation and internal quotation marks omitted).

In June 2002, the FDA approved the atypical drug ziprasidone for intramuscular injection. *See* FDA, Center for Drug Evaluation and Research, *Drug Approvals for June 2002*, *available at* http://www.fda.gov/cder/da/da0602.htm. Ziprasidone has been reported to have a much more favorable side effect profile than the conventional drugs. Regulatory approval of ziprasidone and (in the future) other atypical drugs in injectable form may significantly alter the calculus undertaken by a trial court when it decides whether to order administration of antipsychotic drugs. Although any coercive introduction of antipsychotic drugs constitutes a serious intrusion of the individual's autonomy, that intrusion may be justified when no non-drug therapy would be effective, where the drug clearly would be effective, and where the side effects are likely to be moderate. At the same time, the regulatory approval of atypical drugs in injectable form should mean that, in the future, when the government seeks to administer antipsychotic drugs to restore a defendant to competency, it should not resort to conventional drugs in the first instance but rather should propose to use atypical drugs instead, whenever there is a substantial possibility that those drugs would be effective.[25]

On the other hand, it must be recognized that atypical drugs are not panaceas. Because those drugs are new, the side effects of their long-term use is not yet known. More-

[25] If an aytpical agent that is likely to be effective is not yet available in injectable form, the government should explore administering the drug in a liquefied form, such as an elixir, rather than resorting to conventional drugs.

over, all the atypical drugs have limitations, including ziprasidone (*see* pp. 21-22, *supra*). Finally, while many antipsychotic drugs, including ziprasidone, have been well studied and have been determined by the FDA to be effective for treatment of *schizophrenia*, their effectiveness for delusional disorder is unproven. *See* pp. 16-18, *supra*. Thus, while a court might be justified in ordering injection of ziprasidone to restore the competency of a person with schizophrenia, it is much more doubtful that such coercive treatment would be justified for someone like Dr. Sell.

C. The Trial Court Should Also Consider The Effect Of Antipsychotic Drugs On The Defendant's Fifth And Sixth Amendment Rights To A Fair Trial

The coercive administration of antipsychotic drugs may compromise a defendant's Fifth and Sixth Amendment rights to a fair trial. *See Riggins*, 504 U.S. at 136-138. There are at least three different ways in which these medications may impair a defendant's fair trial rights. First, antipsychotic drugs can appear to "flatten or deaden [the recipient's] emotional responses," *Weston*, 206 F.3d at 20 (Tatel, J., concurring), making the defendant look "so calm or sedated as to appear bored, cold, unfeeling, and unresponsive." *Riggins*, 504 U.S. at 143 (Kennedy, J., concurring). Such alterations in the defendant's demeanor—whether he is testifying on his own behalf or simply sitting next to counsel—can cause "serious prejudice . . . if [the] medication inhibits the defendant's capacity to react and respond to the proceedings and to demonstrate remorse or compassion." *Id.* at 143-144 (Kennedy, J., concurring). Second, the well documented side effects of restlessness, Parkinsonian tremors, muscle spasms, and slurred speech can adversely affect the jury's opinion of a defendant. *See id.* at 142-143 (Kennedy, J., concurring). Third, antipsychotic drugs may undermine the defendant's ability to participate effectively in his own defense by dulling his cognition, and thus compromising his "interaction with

counsel, or his comprehension at trial." *Id.* at 138. Indeed, the Court in *Riggins* found "a strong possibility that [the defendant's] defense was impaired" in that manner. *Id.* at 137.[26]

A court should be particularly attentive to these potential side effects, because they may not appear so significant to a health-care professional as they would appear to a juror, especially if the therapist does not usually work in a forensic health-care field. Compared to the dramatic symptoms of

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[26] In addition, in some cases, the intended effect of administering antipsychotic drugs—namely, suppressing psychotic symptoms—may compromise the defendant's Sixth Amendment right to raise certain defenses at trial. For example, rendering a previously delusional individual competent may impair her ability to mount an effective insanity defense by removing the best evidence of that insanity: the physical manifestations of her own mental state. To be sure, a defendant rendered competent by the administration of drugs might still attempt to mount an insanity defense—by, for example, relying on the testimony of therapists who had treated her before she was medicated, testifying herself about her unmedicated mental state, or introducing a videotape recording of herself prior to the administration of the medication. None of those alternatives, however, is likely to be as effective as the defendant's testimony and courtroom presence in her unmedicated state. Empirical research shows that jurors who think the accused is displaying psychotic symptoms at the time of trial are significantly more likely to return a verdict of not criminally responsible on account of mental disorder than are those who think the accused is symptom-free during the trial. *See* Karen E. Whittemore & James R.P. Ogloff, *Factors That Influence Jury Decision Making: Disposition Instructions and Mental States at the Time of the Trial*, 19 L. & Hum. Behav. 283, 292 (1995); *see also Weston*, 206 F.3d at 21-22 (Tatel, J., concurring).

As with the risk of unfair trial prejudice caused by the side effects of antipsychotic drugs, concern about a defendant's ability to mount an effective defense of insanity or impairment is best addressed at the time of trial. *See* p. 27, *infra*. The trial court will then be able to consider the defenses the defendant proposes to mount, and, to the extent any of them involve claims about the defendant's mental state at the time of the offense, assess whether there are alternative ways for the defendant effectively to mount the defense, including other evidence of her earlier mental state. *Cf. Riggins*, 504 U.S. at 145 (Kennedy, J., concurring).

full-blown schizophrenia or the devastating consequences of tardive dyskinesia, a flat affect or an appearance of restlessness may seem inconsequential. But to a juror who sees only the medicated defendant, an appearance of boredom or restlessness may suggest that the defendant cares little about the judicial proceedings. Thus, the trial court should ensure that the defendant be monitored for such changes in his demeanor.

On the other hand, it may be difficult for the court adequately to evaluate the significance of these side effects for the defendant's trial rights until the drugs have been administered and their effects in the given case are understood. The court would then be able to determine the precise effects of the medication and the likely impact of those effects on the defendant's fair trial rights. *See United States* v. *Weston*, 255 F.3d 873, 886 n.8 (D.C. Cir. 2001). If, at the time of trial, the court determines that the antipsychotic drugs have caused side effects that will impair the defendant's right to a fair trial, the court should conclude that the defendant cannot be tried while medicated.[27]

CONCLUSION

For the foregoing reasons, antipsychotic drugs should not be forcibly administered to a criminal defendant for the purpose of rendering him competent to stand trial unless the

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[27] Some courts have suggested that the trial court should instruct the jury about the defendant's medication and its effects, and admonish the jury not to draw adverse inferences about the defendant based on her appearance and demeanor. *See Weston*, 255 F.3d at 886. Such an approach, however, is likely to be appropriate only in the rare case. First, jury instructions of that kind may seriously prejudice the defendant by informing the jury that the defendant is mentally ill, a fact of which the jury might not otherwise be aware. Second, given the great significance that jurors customarily pay to a defendant's demeanor—which usually forms a fundamental part of their evaluation of her credibility—it may be doubtful that such a cautionary instruction would be effective. *See Riggins*, 504 U.S. at 143-144 (Kennedy, J., concurring); J. Alexander Tanford, *The Law and Psychology of Jury Instructions*, 69 Neb. L. Rev. 71, 95 (1990).

government proves to the trial court that less intrusive non-drug alternatives would be ineffective in accomplishing the same objective; that there is a substantial likelihood that the particular drug proposed to be used will render the defendant competent for trial; and that the benefits from that medication clearly outweigh its side effects. In addition, once antipsychotic drugs are administered and the defendant is brought to trial, the government should be required to show that the drugs will not materially impair the defendant's ability to present an effective defense.

Respectfully submitted.

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In The
Supreme Court of the United States

DR. CHARLES THOMAS SELL,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF THE NEW YORK STATE ASSOCIATION OF CRIMINAL DEFENSE LAWYERS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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STATEMENT OF INTEREST[1]

The New York State Association of Criminal Defense Lawyers (hereinafter "NYSACDL") is a non-profit membership organization of more than 800 attorneys who practice criminal defense law in the State of New York. Its purpose is to assist, educate and provide support to the criminal defense bar to enable its members to better serve the interest of their clients and to enhance their professional standing.

In NYSACDL's view, this appeal, involving the forced medication of a criminal defendant for purposes of rendering him competent to stand trial, presents an issue critical to the fair and just operation of the criminal justice system: the right and ability of a criminal defendant to present a defense of "diminished capacity."

SUMMARY OF THE ARGUMENT

Both the Fifth and Sixth Amendments establish Dr. Sell's right to testify regarding his diminished capacity at the time of the alleged criminal activity. Accordingly, this Court should reverse due to the Eighth Circuit's failure to adequately consider the preeminent import of this and

[1] Pursuant to this Court's Rule 37.2(a), letters of consent from both parties to the filing of this brief have been filed with the Clerk. Pursuant to this Court's Rule 37.6, counsel represent that this brief was not authored in whole or in part by counsel for any party, and that no person or entity other than amicus, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

other clearly established constitutional rights implicated by the government's forced medication of Dr. Sell.

ARGUMENT

I. Dr. Sell Has A Constitutional Right To Present Evidence Of His Diminished Capacity.

In allowing the forcible medication of Dr. Sell, the Eighth Circuit offered only cursory analysis of the constitutional implications of this government action. *United States v. Sell*, 282 F.3d 560, 571-72 (8th Cir. 2002). Mentioning only the possible interference with Dr. Sell's demeanor and ability to assist counsel at trial, the Court of Appeals ignored a host of long-recognized constitutional rights compromised by his forced medication, in particular, Dr. Sell's rights to present a defense and to testify on his own behalf. Firmly grounded in the Fifth and Sixth Amendments, these two rights give rise to Dr. Sell's constitutionally protected right to present a "diminished capacity defense," *i.e.*, the right to present his own unfettered testimony regarding his state of mind at the time of the alleged criminal activity.

A. Diminished Capacity Is An Evidentiary Concept, Not An Affirmative Defense.

The term "diminished capacity defense" is a misnomer that has fostered some confusion within case law, often through the confounding of two distinct concepts. First, "diminished responsibility," an affirmative defense widely accepted only in European countries, "permits the jury to mitigate the punishment of a mentally disabled but sane offender in any case where the jury believes that the defendant is less culpable than his normal counterpart

who commits the same criminal act." *United States v. Pohlot*, 827 F.2d 889, 904 (3d Cir. 1987). In contrast, "diminished capacity" is not an affirmative defense at all, but instead refers to the defendant's introduction of evidence of a mental disorder as a means of negating *mens rea*. Dr. Sell wishes to protect his right to present evidence under this second concept, which is widely accepted in our federal common law. *See, e.g.*, *United States v. Gonyea*, 140 F.3d 649, 651 (6th Cir. 1998); *United States v. Fazzini*, 871 F.2d 635, 641 (7th Cir. 1989); *United States v. Twine*, 853 F.2d 676, 678 (9th Cir. 1988); *Pohlot*, 827 F.2d at 896. As one leading commentator further elaborates:

> [T]he *mens rea* variant of diminished capacity is not a separate defense that deserves to be called "diminished capacity" or any other name connoting that it is some sort of special, affirmative defense. The defendant is simply introducing evidence, in this case evidence of mental abnormality, to make the following claim: "I did not commit the crime charged because I did not possess the requisite *mens rea*." This is not an affirmative defense whereby the defendant admits or has proved against him the elements of the crime charged, but then raises a claim of justification or excuse. Further, a defendant claiming no *mens rea* because of mental disorder is not asserting some lesser form of legal insanity, that is, he is not claiming that he is partially or less responsible for the crime charged. Rather, the defendant is straightforwardly denying the prosecution's *prima facie* case by attempting to cast doubt on the prosecution's claim that a requisite mental element was present at the time of the offense.

Stephen J. Morse, *Undiminished Confusion in Diminished Capacity*, 75 J. Crim. L. & Criminology 1, 6 (1984).

B. Dr. Sell's Right To Present Evidence Of Diminished Capacity Rests In The Fifth And Sixth Amendments.

In reversing the Eighth Circuit, this Court should recognize the constitutional underpinnings of Dr. Sell's right to present evidence of his diminished capacity. Indeed, this right is a logical extension of several long-recognized rights under our Constitution. First, the Sixth Amendment protects Dr. Sell's right to present his own defense. *Faretta v. California*, 422 U.S. 806, 819 (1975). Second, both the Fifth and Sixth Amendments provide his right to testify on his own behalf, *i.e.*, Dr. Sell's fundamental right "to present his *own* version of events in his *own* words." *Rock v. Arkansas*, 483 U.S. 44, 51-52 (1987) (emphasis added). Third, this Court has recognized that the right to testify is of greatest constitutional significance where, as here, the accused potentially seeks to testify regarding his lack of the requisite *mens rea* necessary for conviction. *Crawford v. United States*, 212 U.S. 183, 202-203 (1909); *United States v. Hayes*, 477 F.2d 868, 873 (10th Cir. 1973) ("Where a defendant's intent is in issue he should be permitted to testify as to his motive and actual intent or state of mind."); *United States v. Edwards*, 458 F.2d 875, 884 (5th Cir. 1972) ("[W]e think justice would require that the defendant be given an opportunity to take the stand and state to the jury that he intended no wrongdoing."); *Krogmann v. United States*, 225 F.2d 220, 229 (6th Cir. 1955) ("[T]he rule is well settled that in a criminal proceeding where the intent of the defendant is in issue the defendant may testify as to what his intent was."). Dr. Sell's presentation of a diminished capacity defense – that is, offering his own defense through his testimony regarding the most critical element of the

government's case – flows directly from this bundle of rights.

II. The Eighth Circuit's Opinion Violates Dr. Sell's Right To Present Evidence Of His Diminished Capacity.

This Court should reverse the Eighth Circuit's opinion for failing to even address, let alone appropriately analyze, the significance of the Fifth and Sixth Amendment rights discussed above. The Eighth Circuit's opinion stands in contradiction with *Rock v. Arkansas*' constitutional mandate of allowing Dr. Sell to present "his *own* version [of his state of mind] in his *own* words." Without reiterating the numerous and significant effects of psychotropic medication, *Riggins v. Nevada*, 504 U.S. 127, 134, 141-144 (1992) (Kennedy, concurring), the government's forced administering of these drugs would affect, *inter alia*, Dr. Sell's abilities to "understand and respond to questions while testifying" and to describe the nature and extent of his delusional disorder. Dora W. Klein, *Trial Rights and Psychotropic Drugs: The Case Against Administering Involuntary Medications to a Defendant During Trial*, 55 Vand. L. Rev. 165, 199 (2002). Indeed, psychotropic medication may affect his ability to actually decide to testify in the first instance. *Id.* at 191.

Under the Eighth Circuit's opinion, the government will compel the administering of psychotropic drugs to Dr. Sell and bring him to trial, where he would perhaps take the stand to testify. Yet, in contravention of this Court's precedents, his words would not be his own. They would be the government's.

CONCLUSION

For the foregoing reasons, this Court should reverse the decision of the Eighth Circuit.

Respectfully submitted,

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FOR ARGUMENT

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MOTION FOR LEAVE TO FILE BRIEF AND BRIEF FOR THE AMERICAN PSYCHIATRIC ASSOCIATION AND AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW AS *AMICI CURIAE* SUPPORTING RESPONDENT

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MOTION FOR LEAVE TO FILE BRIEF FOR THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW AS *AMICI CURIAE* SUPPORTING RESPONDENT

The American Psychiatric Association (APA) and the American Academy of Psychiatry and the Law (AAPL) respectfully move for leave to file a brief as *amici curiae* in this case. Although respondent, the United States, has granted consent (by letter filed with the Clerk), petitioner has not.

The APA, with approximately 42,000 members, is the Nation's leading organization of physicians specializing in psychiatry. The APA has participated as *amicus* in many cases involving mental-health issues, including *Kansas v.*

Crane, 532 U.S. 782 (2001), *Olmstead v. L.C. by Zimring*, 527 U.S. 581 (1999), *Kansas v. Hendricks*, 521 U.S. 346 (1997), *Foucha v. Louisiana*, 504 U.S. 71 (1992), *Riggins v. Nevada*, 504 U.S. 127 (1992), *Washington v. Harper*, 494 U.S. 210 (1990), and *Addington v. Texas*, 441 U.S. 418 (1979). It also participated at the court's invitation in *United States v. Gomes*, 289 F.3d 71 (2d Cir. 2002), involving issues similar to those presented here. AAPL, with roughly 2500 psychiatrists dedicated to excellence in practice, teaching, and research in forensic psychiatry, has participated in, *e.g.*, *Crane*, *supra*, *Penry v. Johnson*, 532 U.S. 782 (2001), and *Jaffee v. Redmond*, 518 U.S. 1 (1996).

The members of the APA and AAPL are physicians engaged in treatment, research, and forensic activities, and many of their members regularly perform roles in the criminal justice system. The organizations and their members have substantial knowledge and experience relevant to the issues in this case. Both organizations seek to ensure that the Court has well-grounded facts about antipsychotic medications, including the new generation of medications post-dating *Riggins*, and appreciates the adverse consequences–for the patient, for other patients at an institution, for the legal system's interests–of not giving medications that are the medically appropriate treatment for psychotic illnesses and the only realistic hope of restoring competence.

For these reasons, the APA and AAPL ask that their motion be granted.

Respectfully submitted.

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BRIEF FOR THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW AS *AMICI CURIAE* SUPPORTING RESPONDENT

INTEREST OF *AMICI CURIAE*

Amici's interest is stated in the accompanying motion.[1]

INTRODUCTION

A government can justify involuntary medication to restore a criminal defendant's competence to stand trial on several necessary conditions, most importantly that such medication is medically appropriate for the individual, *i.e.*, warranted on the normal medical grounds balancing the benefits of the medication to the patient against the risks of side effects. The decisions in *United States v. Weston*, 255 F.3d 873 (D.C. Cir. 2001), in *United States v. Gomes*, 289 F.3d 71 (2d Cir. 2002), and in this case allow involuntary medication to restore competence for trial on sufficiently serious charges if the medication is medically appropriate for the individual, it holds a reasonable prospect of serving its purpose of restoring competence, and no realistic alternatives holds a similar prospect of achieving that end. This brief supports that standard.[2] How the medical aspects of that standard apply in a particular case is necessarily a case-specific factual question.

The sufficiency of the government's interest in trying certain charges ultimately requires a value judgment. *Amici* have no distinctive perspective on whether that judgment

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[1] No party authored this brief in whole or in part, and no person except *amici* and their members made a monetary contribution to the preparation or submission of this brief. S. Ct. R. 39.6.

[2] This case presents no question as to capital punishment, which might involve special considerations. Nor does the issue before this Court involve the *procedures* required for involuntary medication; such procedures should recognize that delaying treatment (through years of appeals) can cause not only deterioration in the patient's condition but physical changes in the brain that make later treatment more difficult and less effective.

might vary according to the seriousness of the charges and, if so, what principle might sensibly and workably define any constitutional line. However drawn, the judgment should reflect an accurate appreciation of the medical context and the possible results of refusing medications (*e.g.*, deterioration of condition, increased difficulty of later treatment, warehousing of defendants, loss of evidence and ability to try defendants).

STATEMENT

1. Petitioner, a dentist, has a history of mental illness. Pet. App. 3. He required hospitalization for a psychotic episode in 1982, and he was released following a course of "conventional" antipsychotic medication (haloperidol (Haldol)). JA242; *see* JA151 (second episode: vision of leopard).

In 1997, petitioner was charged with numerous counts of fraud against Medicaid and against private insurance companies, as well as money laundering. He was initially found competent to stand trial and released on bond. At a bond-revocation appearance, he ranted and spat at the magistrate, and the subsequent bond-revocation hearing included evidence of his deteriorating mental condition. New charges of conspiring and attempting to kill a witness and an FBI agent were soon added to the fraud charges. Pet. App. 3, 14. As trial preparations proceeded, petitioner "filed a notice of intent to introduce evidence of a mental disease or defect" (Pet. xii), and his counsel requested a new competency determination. Petitioner was found incompetent based on a diagnosis–by both petitioner's and the government's psychologists–of delusional disorder, persecutory type. Pet. App. 3[3]; *see* Pet. App. 36, JA145,149-51 (describing delusions).

[3] The court of appeals' opinion (Pet. App. 3 n.3) notes that, under the standard classification system set forth in the APA's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* ["*DSM-IV*"] at 296-301 (1994), a delusional disorder is characterized by the presence, for a month or more, of one or more delusions of a non-bizarre nature, *i.e.*, a fixed, firm, evidence-resistant, false belief in "generally plausible ideas that can conceivably occur in real life" (such as being followed, infected, deceived by one's spouse, etc.); lack of visual or auditory hallucinations (false perceptions) indicative of schizophrenia; and lack of general impaired functioning and of otherwise obviously bizarre behavior. If the delusion is of being persecuted, the diagnosis is of "persecutory" type of delusional disorder. Other types involve delusions about, for example, the condition of one's body or erotic attachments. *Id.* The current *DSM-IV-TR* at 323-39 (2000) ("TR" for "Text Revision") is comparable.

While committed, petitioner was under the care of Dr. DeMier, a psychologist, with Dr. Wolfson the consulting psychiatrist. Both determined, and later testified at an administrative hearing, that antipsychotic medications were likely to restore petitioner to competency and to be "the only way he could be restored to competency." Pet. App. 3. After petitioner refused medications, a medical hearing officer (a psychiatrist) "concluded that antipsychotic medication was the treatment of choice" for his psychotic symptoms. Pet. App. 4; *see* JA143-54.

2. At the judicial hearing, Drs. DeMier and Wolfson, on direct and cross-examination, testified to the following:

- Petitioner has a psychosis. Dr. DeMier had adopted the diagnosis of delusional disorder, persecutory type, when petitioner was found incompetent to stand trial. Dr. Wolfson endorsed that diagnosis tentatively, without yet ruling out schizophrenia as an alternative diagnosis, indicating that the appropriate treatment is the same regardless. JA166-68,228-31,257-60. (Earlier, Drs. DeMier and Wolfson both suggested a possible diagnosis of schizophrenia. JA150.)
- The psychosis, whatever the definitive diagnosis, is best treated with antipsychotic medication, which is "clearly indicated" as "the only treatment that we could reasonably expect to improve [petitioner's] condition," given the lackof effective alternatives, the benefits provided, and the recognized but controllable risks of the medications. JA179; *see* JA168,180 (no effective alternatives), 187-91 (side effects), 191 (improvement unlikely without medication), 220-21 (psychotherapy typically not successful with delusional disorder),

229-30, 235 (therapy may help *after* medication, but unlikely "success or meaningful benefit from other therapy interventions" without medication), 266 (same).

• Without antipsychotic medication, petitioner's condition will likely deteriorate, and delayed treatment will likely take longer to work and not work as well. JA168,231.

• Delusions often respond to antipsychotic medication (JA218,230,280-81), and petitioner "can be restored to competency, as a result of treatment with anti-psychotic medications" (JA179). *See* JA245 ("good chance"), 300-02 (citing period of a few weeks to months). Dr. DeMier had two delusional disorder patients who were treated with antipsychotic medications, one with haloperidol (Haldol), one of the older generation, the other with olanzapine (Zyprexa), one of the newer medications, and saw improvements in both and restoration of competence in one (the one given Haldol). JA178-79,187-88. Dr. Wolfson had an 80% success rate on a somewhat larger group of patients. JA244.

• For delusional disorder, the literature discusses one of the older medications, pimozide (Orap), as beneficial, but the newer generation of "atypical" antipsychotics might now be preferable: they have "substantial advantages," notably their "more benign side effect profile" than the conventional antipsychotics. JA239-41.[4]

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[4] Dr. Wolfson mentioned, among the new "atypical" medications, quetiapine (Seroquel) and olanzapine (Zyprexa), as well as ziprasidone (Geodon or Zeldox), and observed that, once medication is ordered, it is reasonable to give patients a choice among appropriate alternatives. (Flexibility in changing medication, without renewed hearings and delays, also makes medical sense.) Dr. Wolfson noted, in 1999, that the atypicals were available only for oral administration, not for injection, so the atypicals called for patient cooperation. JA241,300-01.

In June 2002, an injectable form of ziprasidone (Geodon) was approved for marketing in the United States. *Physician's Desk Reference* 2601 (57th ed. 2003). In Germany, an injectable form of risperidone (Risperdal), another atypical medication, was approved last summer.

• Haldol allowed petitioner's 1982 release from the hospital; reducing the dose controlled a muscle spasm side-effect. JA242-43.

• Although "there is a conventional wisdom that patients with delusional disorder respond less to medication," Dr. Wolfson's experience and the case reports in the literature actually show favorable results in many cases. JA246.

• There are "some potential unpleasant side effects from antipsychotic medications," just as "there are for most medications that are used in any medical specialty." JA236. Stiffness and restlessness problems can occur with conventional (typical, traditional) antipsychotics, but they can be treated; and possible sedating effects can likewise be dealt with. JA236-37. "[M]ost patents don't have to expect problematic side effects as the cost of having their illness treated and having control of their own thoughts and minds." JA237. As for the potentially serious neuroleptic malignant syndrome, the risk is very small, perhaps 1 in 10,000, and the costs of the continuing illness are much greater. JA238-39.

Petitioner submitted a declaration by Dr. Cloninger, a psychiatrist, recommending against medication. Noting that delusional disorder "is a rare condition," unlike schizophrenia, so that psychiatric experience is limited (JA30), he distinguished medication's effectiveness for schizophrenia and its effectiveness for delusional disorder. After citing a 1988 textbook, he reported finding only one article containing "systematic data * * * about the treatment of a large series of cases of Delusional Disorder," a 1993 article reporting "'a long-term follow up study'" of 72 Norwegian patients, comparing the *long-term* results of a group first admitted to hospitals in 1946-1948 (before antipsychotics were introduced) to a group first admitted in 1958-61 (after the earliest antipsychotics were introduced), and finding no "more favorable outcome" for the latter group. JA30-31. "In other words, there is no evidence that neuroleptics are beneficial for patients with Delusional Disorder." JA31; *see* JA31-32.

Dr. Cloninger, noting petitioner's 1982 treatment with antipsychotic medication, stated that petitioner's "delusions did *not* respond as evidenced by his immediately discontinuing treatment" and that petitioner "regarded that treatment as a terrible experience." JA32.[5] Neuroleptics "always are associated with risk of side effects," and "treatments that carry any risk at all" should not be given involuntarily, he wrote, "in the absence of documented evidence of benefit to the person." JA32. He therefore recommended "treatment * * * limited to basic support and voluntary symptomatic treatment," including "a safe supportive milieu with access to exercise and reading material" and voluntary antidepressant medication (paroxetine (Paxil)). JA32; *see* JA149,294. Dr. Cloninger did not testify and so was not cross-examined.

Dr. Wolfson responded to Dr. Cloninger's brief declaration, criticizing its broad conclusions. The absence of large scale, double blind, placebo control studies–which are impractical with delusional disorder (particularly paranoid) patients–does not support a conclusion that medications are ineffective; and case reports and a statistical analysis of prior studies in fact show significant beneficial response. JA247-49,278-79. Moreover, the 1993 article cited by Dr. Cloninger does not show ineffectiveness. It reports only certain *long-term* results (not short-term effectiveness), based on two groups of patients from the era when only the very first antipsychotic medications were available; the article reserves judgment on how informative even as to long-term

[5] Dr. Cloninger did not address the apparent effectiveness of medication in allowing petitioner's release from the hospital in 1982 and did not explain why *ineffectiveness* was shown by petitioner's discontinuance of medication. Patients stop medications for other common reasons: *e.g.*, the medications did their job and are no longer needed; a patient *believes* the medications are no longer needed or (as with delusional disorder) does not consider himself ill or dislikes side effects. The article cited by Dr. Cloninger recognizes the frequency of "noncompliance" (not taking prescribed medication) with delusional disorder patients. *See* note 6, *infra*.

results the lack of difference between the groups is, noting that delusional disorder patients often do not take their medications over time; and the article notes reports of pimozide's benefits for delusional disorder. JA248-50,278-79.[6]

3. The magistrate (like the medical hearing officer previously) found that, with side effects subject to control, the medical benefits of antipsychotic medication far outweigh any risk, such medication was likely to restore competence (enable petitioner to communicate rationally with counsel), and there were no realistic alternatives. Pet. App. 24-26. The district court, noting the ability to control risks of side effects, found that the record supports the same findings and, hence, the order of medication, also noting the prematurity of concerns about any adverse effects from medications on trial rights. *Id.* at 29-46. The Eighth Circuit drew the same conclusions (*id.* at 7-10), basing the judgment *only* on the fraud and money-laundering charges. Pet. App. 7.[7]

[6] The limited significance of the 1993 article for the question of relevance here–short-term effectiveness of any of the whole range of antipsychotic medications now available, including the 1990s generation–is evident in the article itself. Opjordsmoen & Retterstol, *Outcome in Delusional Disorder in Different Periods of Time*, 26 Psychopathology 90 (1993); JA135-43. The paper notes that "pimozide has * * * been reported to be beneficial" for delusional disorder patients. *Id.* at 90. The paper observes that such patients are "often difficult to treat because of denial, projection and reluctance to take drugs" (*id.*) and that, while delusional disorder might be more resistant to treatment than schizophrenia, "[a]nother explanation might be that there are more problems with compliance [patients' actually taking their medication] in delusional disorder than in schizophrenia," for "[p]aranoid patients are usually very sensitive to all side effects of drugs." *Id.* at 93. The paper notes "the difficulties encountered in doing research in this field," so treatment for this disorder "still seems to be terra incognita, and controlled drug trials are strongly needed." *Id.*; *see also* A. Munro, *Delusional Disorder: Paranoia and Related Illnesses* 229 (1999) ("noncompliance with psychiatric treatment is a common feature of delusional disorder").

[7] In disregarding the other charges (attempt and conspiracy to commit murder), the court merely said: "It is possible that [petitioner's] threats

SUMMARY OF ARGUMENT

The similar analyses of the Eighth, Second, and D.C. Circuits should be followed by this Court. Criminal defendants, like others, have an undoubted liberty interest in avoiding forced bodily intrusions, including any kind of medication, psychiatric or otherwise. But the interest is not absolute, and just as avoiding danger to self or others suffices to justify medically appropriate medication, so should the government interest in restoring competence to stand trial (on charges this Court deems sufficiently serious). There are weighty interests in resolving criminal charges and in avoiding the harmful effects of leaving individuals without needed treatment. The crucial conditions are that the medication be medically appropriate, under the normal medical balancing of benefits and risks (taking account of the manageability of risks); hold a reasonable prospect of restoring competence; and be reasonably necessary to achieve the goal, considering alternatives.

The analysis should be the same whether the needed medication is a psychiatric or nonpsychiatric one. Whether particular medications meet the crucial conditions in a particular case is a matter for case-specific determination based on medical judgments. Those judgments take account of the particular illness at issue and whatever likelihood there is of side effects from the typically short-term use of medications needed for the goal of competence restoration.

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after his first indictment were a manifestation of his delusional disorder * * *." Pet. App. 7 n.8. That rationale for ignoring the murder-related charges is unrelated to the interests justifying medication (adjudicating charges). Moreover, that rationale might bar involuntary medication in any insanity-defense case, no matter how serious the offense. If a defendant charged with *actual* murder claimed insanity based on a mental illness that also makes him incompetent, it could equally be said that "[i]t is possible that [the murder was] a manifestation of his [insanity]." Petitioner himself has raised a mental-illness defense, so even the fraud and moneylaundering might be "a manifestation of" his mental illness.

In particular, they take account of the significant advances in antipsychotic medications post-dating this Court's decisions in *Riggins v. Nevada*, 504 U.S. 127 (1992), and *Washington v. Harper*, 494 U.S. 210 (1990), including the new generation of antipsychotic medications that, as a class, have better side-effect profiles than the earlier medications.

Neither First Amendment interests nor Sixth Amendment trial-right interests should alter the basic judgment about justifying involuntary administration of medically appropriate medication. Such medication typically enhances rather than impairs speech interests, and, in any event, the government justification sufficient for due process analysis would suffice under the First Amendment as well. Likewise, appropriate medication typically enhances rather than impairs a defendant's ability to participate effectively at trial, and, in any event, any concerns about possible sedating or other adverse effects on demeanor or testifying ability are properly considered at a later stage, after competence is restored. The defendant may plead guilty and avoid trial; adverse effects often will not occur at all; and any adverse effects are broadly subject to being controlled by adjustment of medication, so the mere possibility of such effects should not stand in the way of restoring competence.

ARGUMENT

I. THE LEGAL FRAMEWORK OF *RIGGINS V. NEVADA* AND *WASHINGTON V. HARPER*

Based on the longstanding legal recognition of personal autonomy, there is a due process liberty interest in refusing unwanted antipsychotic medication, like any other medication, but the interest "is not absolute." *Weston*, 255 F.3d at 876; *see Riggins*, 504 U.S. at 135; *Harper*, 494 U.S. at 220, 222-23. *Harper* and *Riggins* illustrate the two sides of that principle. *Harper* establishes the sufficiency, for justifying involuntary medication, of the state interest in avoiding danger in a custodial setting, where the medication is medially appropriate. *Riggins* recognizes the constitutional interest

itself by holding, as argued by the APA, that the State must justify involuntary medication, which the State had not been required to do in *Riggins* at all. *Riggins*, 504 U.S. at 136.

Riggins makes clear, too, that this principle is properly enforced in the criminal proceeding itself, rather than in a collateral suit challenging unjustified involuntary medication. It was on that question–a point of disagreement with the dissent (*Riggins*, 504 U.S. at 146 (Thomas, J., dissenting))–that it was relevant for the *Riggins* Court (and the APA) to observe that certain medications, especially if given in high doses, *may* affect a criminal defendant's appearance, and role, as a criminal defendant. *See* APA *Riggins* Br. 12-15; *Riggins*, 504 U.S. at 137; *id.* at 142-43 (Kennedy, J., concurring in the judgment) (quoting APA brief).[8] Indeed, Riggins had been given very high doses of thioridazine (Mellaril), a conventional antipsychotic medication with significant sedating effects that many other medications, both older and newer ones, do not have. *Id.* at 137.[9] Such

[8] Possible side effects, differing even among the conventional medications, include restlessness, "parkinsonism" (characterized by tremors or diminished range of facial expression or slowed movements or speech), and sedation. "There is, however, little reliable evidence that properly used antipsychotic medication has any significant adverse effect on attention or perception. And it is well established that the foregoing side-effects are readily subject to reversal or control by adjusting doses or prescribing counteracting medication." APA *Riggins* Br. 10-11 (citations omitted).

[9] *See, e.g.*, J. Preston, J. O'Neal, & M. Talaga, *Handbook of Clinical Psychopharmacology for Therapists* 178-79 (2d ed. 2001) (tables listing medications, dosages, and side effects); P. Weiden, P. Scheifler, R. Diamond, & R. Ross, *Breakthroughs in Antipsychotic Medications* 94 (1999) (publication of National Alliance for the Mentally Ill) (table of conventional medications and side effects); *id.* at 111 (noting differences in sedating effects even among various older medications, let alone among newer ones; even when sedating effects occur, sometimes those effects end after a few weeks; "[s]edation is very sensitive to dose adjustments"). The dosage of Mellaril given to Riggins was 800 mg, the very highest indicated dose. *Riggins*, 504 U.S. at 129, 131.

potential side effects, being relevant to the criminal trial, justify a demand for state justification in the criminal case.

This point must not be overstated. The Court did not decide, and the APA did not urge, that such potential effects *defeat* a State interest in restoring competence or that they even weigh heavily, given that side effects are broadly subject to being monitored and controlled, whether by switching medications, lowering doses, or taking other action. All *Riggins* decided was that (a) a criminal defendant may insist, in the criminal case, on the State justifying involuntary (medically appropriate) medication and (b) dangerousness in custody is sufficient justification (*Riggins*, 504 U.S. at 135; *Harper*, 494 U.S. at 225-26), while the need to restore competence "might" be (*Riggins*, 504 U.S. at 136). And the entire consideration of antipsychotic medications in *Riggins*, as in *Harper*, was in a medical context now dramatically altered: a new generation of medications has, since 1990, transformed practices in the treatment of psychotic illnesses.

II. THE INTEREST IN RESTORING COMPETENCE TO STAND TRIAL CAN JUSTIFY INVOLUNTARY ANTIPSYCHOTIC MEDICATION IF IT IS MEDICALLY APPROPRIATE

Antipsychotic medication should be treated like other medication. Because an individual has a constitutional interest in avoiding any involuntary bodily intrusion, a justification is required to administer any type of medication to an objecting individual, including one who is incompetent to stand trial. The medical, and legal, judgment should be similar whether, for example, antithyroid medications (with their side-effect risks) are being considered for a thyroid condition like Grave's disease (*see* A. Fauci *et al.*, *Harrison's Principles of Internal Medicine* 2026-27 (14th ed. 1998)) or an antipsychotic medication (with its particular side-effect risks) is being considered for a mental illness. In each case, the individual's side of the constitutional balance is protected by the essential requirement of medical appropriateness of the

particular medication for the individual, considering the treatment benefits and risks. On the other side of the balance, the public interest at issue here (adjudicating serious criminal charges) is a great one; and that interest typically is accompanied by additional interests as well.[10]

In undertaking the analysis, it is critical to bear in mind that virtually all medications, whether psychiatric or non-psychiatric, involve risks of side effects.[11] This commonplace

[10] *Amici* here assume that petitioner's refusal of medication was a competent one. Incompetence to stand trial, involving inabilities to understand proceedings or assist in one's defense (*Godinez v. Moran*, 509 U.S. 389 (1993)), is conceptually and practically distinct from competence to make a rational choice about medication. *See* T. Grisso *et al.*, *MacArthur Competence Assessment Tool for Treatment* (1998); Otto *et al.*, *Psychometric Properties of the MacArthur Competence Assessment Tool-Criminal Adjudication*, 10 Psychological Asssessment 435 (1998); Berg *et al.*, *Constructing Competence: Formulating Standards for Legal Competence to Make Medical Decisions*, 48 Rutgers L. Rev. 345 (1996); Bonnie, *The Competence of Criminal Defendants: Beyond Dusky and Drope*, 47 Miami L. Rev. 539 (1993); N. Poythress, *et al.*, *Adjudicative Competence: The MacArthur Studies* (2002). For an individual who is incompetent to *refuse treatment* (as well as to stand trial), autonomy interests are weakened and state *parens patriae* interests are strengthened. The question here assumes no such special weakening of autonomy interests and addresses the State's interest in restoring competence to stand trial, not other state interests, as justification for involuntary medication.

[11] *See, e.g.*, A. Komaroff, ed., *Harvard Medical School Family Health Guide* 1151 (1999) ("Every medication, including nonprescription drugs, has the potential to cause side effects or adverse reactions."); D. Tapley, *et al.*, eds. *Columbia University College of Physicians & Surgeons Complete Home Medical Guide* 836 (3d rev. ed. 1995) ("All drugs–even aspirin–can have unpleasant side effects in some people."); R. Berkow, *et al.*, eds., *Merck Manual of Medical Information, Home Edition* 26 (1997) ("Most drugs * * * have some undesired effects."; "Since all drugs can harm as well as help, safety is relative. The wider the margin of safety (therapeutic window)–the spread between the usual effective dose and a dose that produces severe or life-threatening side effects–the more useful the drug."; "Some drugs must be used despite their having a very narrow

fact is recognized, for example, in the longstanding law governing drug approval, under which "safety" itself is always a balancing of benefits and risk. *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 142 (2000) ("virtually every drug or device poses dangers under certain conditions"); *id.* at 140 ("safety" under FDCA means that a drug's or device's "probable therapeutic benefits must outweigh its risk of harm").[12] Medical decisions always involve balancing such risks against the benefits of the medication in (a) relieving suffering and (b) improving functioning. *See Weston*, 255 F.3d at 876-77 (medical appropriateness, as judged by professionals, is measured "by examining the capacity of antipsychotic drugs to alleviate [the individual's] schizophrenia (the medical benefits) against their capacity to produce harm (the medical costs, or side effects)"). That balance is part of the medical appropriateness determination itself, as the testimony and findings here confirm, whether the subject is antipsychotic medication for a mental illness or nonpsychiatric medication for a non-mental illness.

A. Antipsychotic Medications Are An Accepted, Often Essential Treatment for Many Psychoses

Antipsychotic medications are not only an accepted but often essential, irreplaceable treatment for psychotic illnesses,

margin of safety."; examples are anticlotting drug, warfarin, and antipsychotic drug, clozapine).

[12] *Id.* at 142 ("drugs are safe within the meaning of the Act because, for certain patients, the therapeutic benefits outweigh the risk of harm"); *United States v. Rutherford*, 442 U.S. 544, 556 (1979) (safety means that the "potential for inflicting death or physical injury is not offset by the possibility of therapeutic benefit"); *FTC v. Simeon Management Corp.*, 532 F.2d 708, 714 (9th Cir. 1976) (per Kennedy, J.) ("many risky medical procedures may be regarded by the FDA as 'safe,' in light of their greater potential benefits."); U.S. Brief in *Rutherford* at 31-32 ("A drug is 'safe,' within the meaning of the Act, if the benefits expected to be achieved through its administration outweigh the costs or risks incurred. No drug is completely 'safe' in the lay person's sense of the word, since every drug—aspirin not excepted—involves risks.") (footnotes omitted).

as most firmly established for schizophrenia, because the benefits of antipsychotic medications for patients with psychoses, compared to any other available means of treatment, are so palpably great compared with their generally manageable side effects. *See Weston*, 255 F.3d at 877 n.2. That was so for the antipsychotic medications prevalent in 1990: *e.g.*, haloperidol (Haldol), thiothixene (Navane), chlorpromazine (Thorazine), thioridazine (Mellaril), or pimozide (Orap). *See* B. Sadock & V. Sadock, *Kaplan & Sadock's Comprehensive Textbook of Psychiatry* ch. 31.17 at 2356-77 (7th ed. 2000) ["*Textbook*"] ("Dopamine Receptor Antagonists (Typical Antipsychotics)"). It remains true with the post-*Riggins* generation of antipsychotic medications, which, while each carrying its own combination of side-effect risks (like virtually every drug), have lower risks of the older drugs' more troublesome side effects. The newer drugs include risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), and ziprasidone (Geodon (elsewhere, Zeldox)). *See Breakthroughs in Antipsychotic Medications* at 94-95; *Textbook* ch. 31.26 at 2455-74 ("Serotonin-Dopamine Antagonists").[13]

1. Conventional Antipsychotic Medications. Even at the time of *Riggins*, before the atypicals, antipsychotic drugs were central to treating both acute and chronic psychoses such as schizophrenia. In 1987, the National Institute of Mental Health concluded that such drugs "remain the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness," having "a dramatic effect on the symptoms of schizophrenia (e.g., delusions, hallucinations, and thought disorder) within 4-6 weeks, although improvement may continue well after that interval." Kane, *Treatment of Schizophrenia*, 13 Schizophrenia Bull.

[13] As the *Textbook* chapter titles show, the older medications worked principally through their effect on dopamine, one of the neurotransmitter amino acids, while both dopamine and serotonin (another neurotransmitter amino acid) are affected by the newer generation.

133, 134, 142 (1987). The drugs were similarly central to long-term treatment of chronic psychosis, being "of enormous value in reducing the risk of relapse and rehospitalization." *Id.* at 143. Medication was commonly essential: "The available data do not support the feasibility of substituting any psychotherapeutic strategy for drug treatment on an indefinite basis." *Id.* at 142; *see* Kane *et al.*, *Clozapine for the Treatment-Resistant Schizophrenic*, 45 Archives Gen. Psychiatry 789 (1988) (earliest of newer medications).

That accepted standard of care, even in 1990, fully accounted for side effects, reflecting the devastating character of the illnesses being treated.[14] This Court reviewed some of the side effects of the older antipsychotic medications in

[14] *See* Paul, "The New Pharmacotherapy of Schizophrenia," in A. Breier *et al.*, *Current Issues in the Psychopharmacology of Schizophrenia* xvii-xviii (2001) (schizophrenia afflicts ½-1% of the world's population, "is associated with a high degree of morbidity and mortality" (including a 10% suicide rate), and "the illness almost invariably requires institutionalization and both acute and chronic intervention (at great emotional and financial expense), " but "effective pharmacotherapy is available for most patients with this disorder"); J. Gorman, *The Essential Guide to Psychiatric Drugs* 197-98 (3d ed. 1997) ("there is no debate that schizophrenia is a horrible illness. It strikes people in late adolescence to early adulthood and often never goes away. * * * [Most] endure many hospitalizations, are unable to work, and have little social interaction. Schizophrenia devastates the early adult years of most patients. The situation is almost equally grim for families * * *. Living with a [person with schizophrenia] is usually a full-time and harrowing job. The patient lives in his or her own world, entertaining bizarre ideas and listening to voices. He may talk without making sense, pace the floors all night, and occasionally become violent or threatening. Parents, acting as if they have toddlers, are afraid to leave their [children with schizophrenia] alone. They, like the patient, become prisoners of the illness. So, although schizophrenia may seem romantic or interesting to philosophers, it is plainly awful to its victims. * * * The hallmarks of schizophrenia are hallucinations, delusions, thought disorder, and disorganized behavior. These[] are often called positive symptoms. There are also negative symptoms such as abnormal affect, loss of motivation, and social isolation.").

Harper, 494 U.S. at 229-30 (describing acute dystonia; akathisia; neuroleptic malignant syndrome; and tardive dyskinesia); *see Riggins*, 504 U.S. at 134. But it was true even in 1990 that "[m]ost of th[e] side-effects *** may be controlled by lowering dosages or by adding another medication; such side effects ordinarily cease when antipsychotics are discontinued." APA *Riggins* Br. 10 (footnote on tardive dyskinesia omitted); *see Weston*, 255 F.3d at 877 ("While there are potential side effects, the professional judgment of the medical experts was that 'each of these potential side effects is generally manageable.'"); note 9, *supra* (even among conventional medications, wide variation in sedating effects). With respect to tardive dyskinesia, two facts are especially significant for short-term treatment of most psychoses: *first*, "[a]lthough the risk of TD is frightening and serious, so is the risk of allowing acute psychosis to remain uncorrected" (*Essential Guide to Psychiatric Drugs* at 219); *second*, "TD virtually never develops after only a few weeks or months of taking the antipsychotic drugs." *Id.*[15]

2. The Newer Antipsychotic Medications. The medical context "has changed substantially during the 1990s." *Textbook* at 1199. With the newer medications, it is all the more firmly true that medications are commonly essential to

[15] Tardive dyskinesia appears to develop at rate of "about four percent per year of cumulative drug exposure for at least the first five years" with the older medications. Kaye & Reed, *Tardive Dyskinesia: Tremors in Law and Medicine*, 27 J. Am. Acad. Psychiatry & L. 315, 315 (1999); *see* Kane & Malhotra, *Clinical Psychopharmacology of Schizophrenia and Psychotic Disorders*, in G. Gabbard, ed., *Treatments of Psychiatric Disorders* 1027, 1038 (3d ed. 2001) ("Prospective studies have suggested an incidence of 5% per year of antipsychotic exposure in young adults, with a substantially higher incidence in elderly persons. The majority of cases are mild and not necessarily progressive even with continued antipsychotic exposure. However, some patients develop a severe and disabling form of the condition. If medication can be discontinued, the prognosis is often favorable, but discontinuation is often not feasible.").

responsible treatment of psychoses like schizophrenia.[16] The newer "atypical" antipsychotic drugs not only have proved effective for many people (including some for whom typicals did not work well) but are widely recognized to "have a 'more favorable side effect profile'" as a class than the older medications, as the testimony in *Weston* established and Dr. Wolfson's testimony in this case reiterates. *See Weston*, 255 F.3d at 877 n.3 (noting side effects *as a class*; importantly, *amici* note, side effects differ even among the atypicals).

It is important to avoid generalizations that either oversimplify or get ahead of the ever-continuing research on particular medications.[17] Nevertheless, it is clear that major

[16] *See also* Kane & Malhotra, *supra*, at 1027-28 ("Pharmacological treatment is a critical component in the short- and long-term management of schizophrenia."); *Handbook of Clinical Psychopharmacology for Therapists* at 177 ("Antipsychotic medications have truly revolutionized the treatment of psychotic disorders. Their effectiveness is so vastly superior to previous treatments that they have ushered in a new era in the treatment of severe mental illnesses."); Baldessarini, *Psychophar-macology*, in A. Nicholi, Jr., ed., *The Harvard Guide to Psychiatry* 444, 450 (3d ed. 1999) (effectiveness within a few days or weeks; "acute psychosis or exacerbations of chronic psychosis, especially of schizophrenia, are routinely treated with antipsychotic medications in adequate doses"); Marder, *Antipsychotic Medications*, in A. Schatzberg & C. Nemeroff, *The American Psychiatric Press Textbook of Psychopharmacology* 309 (2d ed. 1998) ("these drugs have become standard treatments in psychiatry and medicine"); Geddes, *Prevention of Relapse in Schizophrenia*, 346 N.E.J. Med. 56 (2002) ("the preponderance of the evidence now supports the use of risperidone as a first-line treatment for patients with schizophrenia, both to induce remission and to prevent relapse"). (The last-cited article updates Geddes, *Atypical Antipsychotics in the Treatment of Schizophrenia: Systematic Overview and Meta-Regression Analysis*, 321 British Med. J. 1371, 1375 (2000) (atypicals and typicals comparably effective and tolerable overall; atypicals cause fewer "extrapyramidal" side effects; recommending use of typicals first).)

[17] Sources describing particular drugs and what is known about them, including their own risks of side effects, include the *Textbook* sections cited above; *The Essential Guide to Psychiatric Drugs*, *supra*; *Breakthroughs in Antipsychotic Medications*, *supra*; A. Breier *et al.*, eds.,

progress has been made, particularly in reducing the traditionally most troublesome side effects (and also in helping previously hard-to-treat psychoses), by the introduction of the newer atypical medications in the last decade. *See Weston*, 255 F.3d at 886 n.7 ("Antipsychotic drugs have progressed since Justice Kennedy discussed their side effects in *Riggins*. There is a new generation of medications having better side effect profiles."). Each such medication, like any medication, has its own side-effect risks: for example, for some of them, a risk of weight gain and, from long-term use, a risk of diabetes. But the side-effect profiles are significantly improved from the older generation, and the improvements include what strongly appears, from an accumulating body of evidence, to be a substantial reduction of the risk of tardive dyskinesia.[18] As one paper noted, because of the lower risks

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Current Issues in the Psychopharmacology of Schizophrenia (2001); and the APA's *Practice Guideline for the Treatment of Patients With Schizophrenia*, 154 Am. J. Psychiatry No. 4 (April 1997 Supp.); *see also* Rivas-Vazquez *et al.*, *Atypical Antipsychotic Medications: Pharmacological Profiles and Psychological Implications*, 31 Prof. Psychology: Res. & Prac. 628 (2000) ("newer antipsychotic agents may make patients with schizophrenia more amenable to psychosocial and rehabilitative interventions").

[18] Kane & Malhotra, *supra*, at 1027 ("Overall, the new-generation antipsychotic drugs do provide clear advantages in terms of reducing adverse effects (particularly drug-induced parkinsonism, akathisia, and, it is hoped, tardive dyskinesia)."); *id.* at 1034-35 (for olanzapine, a 1997 study showed "a significantly lower incidence of treatment-emergent dyskinesia among olanzapine-treated patients") (citation omitted); *id.* at 1035 ("In summary, as a class, the second-generation antipsychotics clearly have advantages over conventional drugs particularly in the area of adverse effects (with the exception of weight gain [a side effect of some, but not all, of the newer drugs])."); Kaye & Reed, *supra*, at 316 ("after over 10 years of clinical use, there are still no confirmed cases of TD from exposure to clozapine"; for risperidone, olanzapine, and quetiapine, "evidence for increased safety" is "impressive. The apparent incidence of TD with risperidone is between 0.03 and 2.4 percent. With olanzapine the

of neuromuscular problems, the standard of care for schizophrenia is rapidly moving toward the newer antipsychotics, even with their own side effects, as the first line of treatment.[19]

3. Delusional Disorder. The effects of medication for a particular individual with a particular diagnosis is a matter for a case-specific factual determination, as was made based on expert testimony at multiple judicial levels in this case. *Cf. Graver Tank & Mfg. Co. v. Linde Air Prods. Co.*, 336 U.S. 271, 275 (1949) (under "two court" rule, Court rarely disturbs concurrent findings, or case-specific applications of accepted legal principles, of two courts below); *Neil v. Biggers*, 409 U.S. 188, 193 n.3 (1972). Nevertheless, some general information about delusional disorder–the relatively rare disorder (compared to schizophrenia) that is, at least tentatively, involved in this case–is useful in considering the record here. As that record indicates, the evidence respecting treatment of delusional disorder is less definitive than for schizophrenia

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incidence of TD is 0.5 to 1 percent compared with 4.5 to 7.5 percent for haloperidol.") (footnotes omitted)

Aside from the reduced risk of tardive dyskinesia from the new medications, there is some evidence, since *Riggins*, that the abnormal involuntary movements characteristic of tardive dyskinesia are at least partly the result of the psychotic illness itself, *rather than* of the medications. Gervin *et al.*, *Spontaneous Abnormal Involuntary Movements in First-Episode Schizophrenia and Schizophreniform Disorder: Baseline Rate in a Group of Patients From an Irish Catchment Area*, 155 Am. J. Psychiatry 1202 (1998); Khot *et al.*, *Not All That Moves Is Tardive Dyskinesia*, 148 Am. J. Psychiatry 661 (1991); *see* Weiden, *supra*, at 109 (tardive dyskinesia can worsen upon stopping older medications, which may, during use, suppress symptoms of the disease).

[19] Kaye & Reed, *supra*, at 331; *see* Pinals & Buckley, *Novel Antipsychotic Agents and Their Implications for Forensic Psychiatry*, 27 J. Am. Acad. Psychiatry & L. 7 (1999). Progress in this field is continuing. *See* note 4, *supra* (new injectable atypicals); Brook *et al.*, *Intramuscular Ziprasidone Compared With Intramuscular Haloperidol in the Treatment of Acute Psychosis*, 61 J. Clinical Psychiatry 933 (2000); Geddes (2002), *supra*.

and other more common psychotic illnesses (which also are less resistant to collecting systematic data); fairly recent summaries can be found in the pertinent chapter of the 2000 *Textbook* at 1243-64 (Manschreck, *Delusional Disorder and Shared Psychotic Disorder*), and the 1999 Munro book, *supra*. Against this background, the testimony of Drs. DeMier and Wolfson, including the responses to Dr. Cloninger, supports the findings about medication here–its medical appropriateness, the prospects for restoring competence, and the lack of realistic alternatives.

Patients with delusional disorders are relatively uncommon, have often not been identified in a distinct diagnosis, are outside many clinicians' experience, and have been difficult to study systematically because they "do not regard themselves as mentally ill and actively oppose psychiatric referral." *Textbook* at 1243, 1244, 1248-50. Although, for such reasons, delusional disorder "has generally been regarded as resistant to treatment" (*id.* at 1262), "[l]imited but growing evidence supports * * * [delusional disorder's] distinctiveness from schizophrenia and mood disorder as well as its treatability." *Id.* at 1243; *id.* ("recent reports suggest that favorable responses to psycho-pharmacologic and psychotherapeutic interventions are more common than previously thought"). Although the disorder can remit over time, it also can be lifelong; it generally develops by "gradual, progressive involvement with the delusional concern"; meanwhile, patients "suffer" and "often feel demoralized, miserable, isolated, and abandoned." *Id.* at 1261-62. Non-pharmacologic treatments have "not been studied enough to justify recommendation." *Id.* at 1262. Medication has been more successful, though "the results required to support this practice *empirically* have been only partially obtained." *Id.* at 1262 (emphasis added). In particular, case reports and studies based on them–which are "especially valuable" as evidence (*id.* at 1263) given the difficulties of obtaining more systematic studies–have shown success with pimozide

(Orap), an older medication, lesser success with other typical neuroleptics, and some success with "atypical" medications. *Id.* at 1251, 1253, 1262-63.

Dr. Munro, a leading researcher in the field, likewise noted in 1999 the "gloomy outlook" among "physicians not familiar with the modern literature"; observed that this "illness which, if allowed to go untreated, is certainly both severe and disabling"; and concluded that "[m]any anecdotal treatment results, and a small number of double-blind drug trials, appear to show a consensus that delusional disorder, despite its traditional resistance to treatment, can now be regarded as an eminently treatable illness." *Munro* at 3-4, 6. He added that "pimozide tends to be the most widely used drug" and "appears to give very good results, but * * * the evidence is still insufficient to know whether it is inherently superior to other neuroleptics in treating delusional disorder." *Id.* at 6.

Munro explained that delusions "can fluctuate in intensity over time, even in the absence of treatment"; and treatment does not "necessarily *cure* delusions, but * * * can allay them to the point where they are either no longer evident or interfere minimally with normal functioning." *Id.* at 32. One reason the reports of treatment are still mostly "anecdotal" (*i.e.*, reports of small numbers of cases, not statistically large samples), *id.* at 227, is "the notorious reluctance of delusional disorder patients to engage in psychotropic drug trials." *Id.* at 229; *id.* at 237 ("delusional disorder patient's excessive wariness and suspicion" may make "conventional double-blind drug trials * * * all but impossible"). The reports "overall add[] up to a refutation of the belief that delusional disorder is irremediable," and "[v]irtually all of these reports refer to psychopharma-cological treatment." *Id.* at 227; *see id.* at 234 (no evidence "suggests that psychological approaches are effective in treating actual delusional disorder"). As to doses and duration: starting with a very low dose (1-2 mg daily) of pimozide or other medication, and gradually increasing (up to 4-6 mg), "it takes about two

weeks of continuous, adequate treatment to produce significant amelioration of the delusion," though "in some patients it may be six weeks or longer." *Id.* at 233. As of 1999, pimozide was "the best documented and most cost effective intervention in delusional disorder." *Id.* at 238. Although "[t]reatment aspects of delusional disorder are in crying need of good, experimentally-based drug trials" (*id.* at 240), Munro concluded in 1999: "delusional disorder, properly diagnosed and adequately treated, has an optimistic outlook. Whatever the neuroleptic employed, the overall rate of response, total or partial, is approximately 80 per cent, an outcome that compares well with any other in psychiatry. It is clearly desirable to identify and, if possible, treat cases." *Id.* at 237.[20]

B. The Interests Supporting Medication Are Weighty

This Court has often described the "compelling interest in finding, convicting, and punishing those who violate the law." *Moran v. Burbine*, 475 U.S. 412, 426 (1986); *accord Texas v. Cobb*, 532 U.S. 162, 172 (2001); *Gray v. Maryland*, 523 U.S. 185, 202 (1998) (Scalia, J., dissenting); *McNeil v. Wisconsin*, 501 U.S. 171, 181 (1991); *Richardson v. Marsh*, 481 U.S. 200, 210 (1987); *Garrett v. United States*, 471 U.S. 773, 796 (1985) (O'Connor, J., concurring); *Winston v. Lee*, 470 U.S. 753, 762 (1985). More pointedly, the interest in adjudicating the charges, one way or the other, is a great one. *See Riggins*, 504 U.S. at 135-36 (quoting *Illinois v. Allen*, 397 U.S. 337, 347 (1970) (Brennan, J., concurring): "[c]onstitutional power to bring an accused to trial is fundamental to a

[20] *See* Felthous *et al.*, *Are Persecutory Delusions Amenable to Treatment?*, 29 J. Am. Acad. Psychiatry & L. 461 (2001) (describing reasons for lack of systematic studies; summarizing evidence of positive results of medication; noting limitations–seven patients, short treatment, long-term delusions–of Silva, *Effects of Pimozide on the Psychopathology of Delusional Disorder*, 22 Prog. Neuro-Psychopharmacol. & Biol. Psychiatry 331 (1998)). The chapter relied on by Dr. Cloninger (JA91-135), from 1988, notes that "[a]ntipsychotic medication may be useful." JA106.

scheme of 'ordered liberty' and prerequisite to social justice and peace"). The Court has also recognized the public interest in *prompt* adjudication. *See Flanagan v. United States*, 465 U.S. 259, 264-65 (1984); *Barker v. Wingo*, 407 U.S. 514, 519-20 (1972).

Importantly, these interests supporting restoration of competence rarely stand alone when medication is medically appropriate. Although a defendant may judge the risk of conviction an overriding one, or otherwise wish to forego the benefits of needed medication, the Court should not ignore the real costs of leaving a defendant untreated when he needs such treatment. These include the costs to the defendant himself (a concern that is especially strong if competency to make treatment decisions is also impaired). Languishing without treatment leaves in place the suffering and impairment of functioning that psychoses cause–the core reasons for medication qualifying as medically appropriate. In addition, there is evidence (though it is not definitive) that delaying treatment, like allowing other kinds of disease to fester, can cause physical alterations (here, in brain structures) to make a psychotic condition worse, harder to treat, and more likely to recur after treatment.[21] The costs for the individual include, as well, the other individual harms from needless institutionalization the Court recognized (at the APA's urging) in *Olmstead v. L.C. by Zimring*, 527 U.S. 581 (1999).

Though treatment should not be given unless appropriate for the individual, of course, other individuals also are ad-

[21] *See* J. Preston, *supra*, at 112 ("there is now evidence to support the notion that being psychotic is damaging to the brain"); Loebel *et al.*, *Duration of Psychosis and Outcome in First-Episode Schizophrenia*, 149 Am. J. Psychiatry 1183 (1992); Wyatt, *Neuroleptics and the Natural Course of Schizophrenia*, 17 Schizophrenia Bull. 325 (1991); Baldessarini, *supra*, at 451 ("There is some evidence that abrupt discontinuation of antipsychotic medication is associated with more frequent and earlier relapses * * *."); *Textbook* at 38-40, 1198 (untreated episodes may create brain structures worsening illness and making it more refractory).

versely affected by leaving the individual untreated. The families of severely disturbed individuals suffer many consequences of their loved ones' psychoses, through both the loss of self and the behavior such psychoses cause. And when an individual is in an institution, leaving him untreated can be unhealthy for other individuals served by the institution, even when the individual is not physically dangerous. The treatment environment is important, as reflected in the emphasis over the past decades on de-institutionalization and improvement of institutions. That environment is harmed, *e.g.*, impairing calm and confidence, by exposure to the agitation, disruption, senseless communication, and languishing associated with untreated psychoses. *See* Amarasingham, *Social and Cultural Perspectives on Medication Refusal*, 137 Am. J. Psychiatry 353 (1980); Abroms, *Defining Milieu Therapy*, 21 Archives Gen. Psychiatry 553 (1969).

Leaving untreated a defendant who is incompetent to stand trial harms other public interests too. If enough time passes, the government may lose its ability to try the charges at all. With competence unlikely to return without medication, there is a genuine potential for defendants to refuse medication for lengthy periods–the more serious the charges, perhaps, the greater the potential–while waiting for evidence to grow stale or the cases against them otherwise to weaken. And since refusal of medication often will leave the individual confined, the government will incur mounting costs of institutionalization. A collateral consequence of institutionalizing many patients who cannot be given medically appropriate treatment, moreover, is damage to the government's ability to hire and retain professional staff, forced to act more as jailers or custodians than as caregivers.

Under 18 U.S.C. §§ 4241, 4246, there is a realistic possibility of long-term, open-ended confinement of many criminal defendants found incompetent to stand trial. Confinement is allowed if incompetence remains and "release would create a substantial risk of bodily injury to another person or serious

damage to property of another." *Id.* § 4246. The relevant risk is *not* judged by reference to restraints possible in prison. Many criminal defendants who are incompetent to stand trial would remain confined indefinitely under this statute (let alone under broader standards Congress might choose to adopt for defendants incompetent only as a result of their own refusal of appropriate medication). Without needed medication, restoration of competence is unlikely according to the best medical prediction at the time of decision, and in any event the possibility is not bounded by any knowable duration. Given the dearth of comparably effective alternatives to antipsychotic medication, a defendant may remain incompetent to stand trial indefinitely.

Whatever constitutional questions might arise on a full analysis, indefinite confinement in likely circumstances of incompetence based on refusal of medication is not precluded by *Jackson v. Indiana*, 406 U.S. 715 (1972). Jackson was not being held under a finding of dangerousness, so the decision is inapplicable to standards for confinement based on danger. In any event, all *Jackson* held was that, when an individual was confined (outside normal civil commitment processes) for the purpose of restoring competence, that confinement became impermissible if the individual *could not* be restored to competence, because such confinement is not reasonably related to its purpose. But *Jackson* does not restrict the confinement of an individual who voluntarily prevents his own restoration to competence–for whom confinement *is* reasonably related to the purpose of the confinement.

C. First Amendment and Fair Trial Interests Should Not Alter the Constitutional Balance

1. Speech Interests. First Amendment interests do not alter the constitutional balance for antipsychotic medications that are justified under the due process standard already discussed. The medications, when appropriate, aim to clear the hallucinations and delusions produced by psychosis, or to allow the patient to recognize and control their dominating

influence. They thus alleviate the mental suffering and functional impairments, producing "*loss* of freedom," characterize severe mental illness. *See DSM-IV-TR* at xxxi (emphasis added). The medications, when properly used to treat the severely mentally ill, positively *promote* First Amendment interests by enhancing abilities to concentrate, read, learn, and communicate. The evidence contradicts the "view of these drugs as mind-altering, thought-inhibiting, or destructive of personality in a negative sense. In fact, the beneficial effects of the medication on complex aspects of mentation suggest that the opposite conclusion is true: the medications reinforce the most important aspects of mental functioning."[22] Relatedly, as the APA explained in *Riggins*, "[t]he mental health produced by antipsychotic medication is no different from, no more inauthentic or alien to the patient than, the physical health produced by other medications, such as penicillin for pneumonia (which might be labeled 'synthetic fitness' or 'synthetic health')." APA *Riggins* Br. 9; *see Riggins*, 504 U.S. at 141 (Kennedy, J., concurring in the judgment).[23]

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[22] Gutheil & Appelbaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 Hofstra L. Rev. 77, 119 (1983); *see* Felthous, *supra*, at 466 ("Rather than mind restricting, the medication is mind liberating."); Appelbaum & Gutheil, *Rotting With Their Rights On*, 7 Bull. Am. Acad. Psychiatry & L. 306, 310 (1979).

[23] "These days, when people are treated with modern psychiatric medication, one of the most common remarks therapists hear once the medications begin to take effect is, 'I am beginning to feel like myself again.' This is a very important point to emphasize. Although some medications do have unpleasant side effects, and some misuse of these drugs certainly continues, the goal of appropriate psychiatric treatment is twofold: (1) to reduce human suffering and (2) to promote the development and expression of autonomy. This a far cry from the chemical straitjackets of the mental hospitals' back wards in the 1950s." J. Preston, *Consumer's Guide to Psychiatric Drugs* 14 (2000)

In any event, the analysis does not change by adding any First Amendment interest to the personal-autonomy interest protected by due process standards. "[G]overnment regulation is sufficiently justified if it is within the constitutional power of the Government; if it furthers an important or substantial governmental interest; if the governmental interest is unrelated to the suppression of free expression; and if the incidental restriction on alleged First Amendment freedoms is no greater than is essential to the furtherance of that interest." *United States v. O'Brien*, 391 U.S. 367, 377 (1968). Those conditions are met if the due process justification is established–if the medication is needed to serve the public interest in adjudicating serious criminal charges, an interest unrelated to suppressing any free expression.

2. Fair Trial Interests. The Court (and the APA) in *Riggins* acknowledged that antipsychotic medication *can* create adverse effects on a defendant's role at trial, thus triggering a duty of justification on the part of the government enforceable in the criminal case. But the interest in avoiding such effects does not alter the basic weight of the competence-restoration justification. In the majority of cases, resolved by guilty plea, effects at trial are immaterial. Moreover, unless there is an unusual reason to know otherwise at the outset, legitimate interests in avoiding unjustified adverse inferences by the jury can readily be addressed *after* competence is restored. Finally, an interest in "appearing psychotic" does not deserve significant weight.

The effect of administering appropriate medication will, in all likelihood, be the very opposite of *impairing* trial rights. Such medication likely will "'enhance some of Weston's trial rights, particularly his right to consult with counsel and to assist in his defense.'" *Weston*, 255 F.3d at 883 & n.6. Moreover, such medication "will more likely improve," not impair, "Weston's ability to relate his belief system to the jury." *Id.* at 884. And, while a criminal defendant has a "right to be present at trial in a state that does not prejudice

the factfinder against him"–which could occur through, *e.g.*, a "flattened emotional affect" from some medication–"medication will likely enhance rather than impair [a defendant's] right to a fair trial," including by restoring the ability to present more appropriate facial responses. *Id.* at 885.

Critically, although "[t]he possibility of side effects from antipsychotic medication is undeniable," the ability of "treating physicians and the district court to respond to them substantially reduces the risk they pose to trial fairness." *Weston*, 255 F.3d at 885. The effects can be monitored and typically controlled (*id.* at 885-86), whether through choosing among the medications (which have widely varying risks of side effects on movement, sedation, etc.), reducing dosages, adding a counteracting medication, or otherwise. Physicians' ability to control such effects, moreover, can be directly supplemented—for purposes of alleviating any illegitimate adverse effect on the defense–by the district court's management of the case. The district court can inform the jury of the medication and its effects and can allow testimony on those effects, disabusing the jury of adverse illegitimate inferences from demeanor. *Id.* at 886. With those bases for addressing fair-trial concerns, the *Weston* court sensibly concluded: "Whether antipsychotic medication will impair Weston's right to a fair trial is best determined when the actual effects of the medication are known, that is, after he is medicated." 255 F.3d at 886 n.8. The *Gomes* court and the Eighth Circuit here reached the same sound conclusion.

A case involving a defense of insanity should not be materially different. The constitutional analysis should focus on reliable evidence, not tactical considerations that, though they may be real, exploit *unfair* or *unreliable* evidentiary inferences. With the ability to monitor and control harmful demeanor effects, the ability to inform the jury of medication's effects, and the availability of other more probative evidence on the issue of insanity, there is a relatively "small risk" that a jury would take a medicated defendant's "testi-

mony (if he decides to testify) as an indication that he must have been sane at the time of the crime, or that he is making it up, or that he deserves no sympathy." *Weston*, 255 F.3d at 884. The same assessment applies to the defendant's general appearance at trial, whether as witness or at counsel table.

Any interest a defendant may have in affirmatively appearing before the jury in an unmedicated state does not warrant being given significant weight here. Most basically, where medication is needed to restore competence, denying medication cannot generally produce the trial (with defendant unmedicated) that this interest invokes. Seemingly, the defendant would have to take medication to become competent, then waive his competence at trial (if waiver is lawful), then stop medication and return to incompetence for trial. But petitioner objects even to the first step; in any event, there is surely a strong interest in not *requiring* the judicial system to try an incompetent defendant.[24]

In addition, the evidentiary significance of demeanor in legitimately establishing the defendant's insanity at the time of a crime is not particularly strong. An individual's psychotic state may not be evident in his or her appearance or demeanor. A person who appears calm may be no more or less insane–"as a result of a severe mental disease or defect, [he] was unable to appreciate the nature and quality or the wrongfulness of his acts" (18 U.S.C. § 17)–than an individual who exhibits anxious or active forms of behavior. Moreover, even without medication, a defendant's courtroom demeanor may differ from what it was at the time of the charged offense: time, the courtroom setting, or the structured prison environment can alter demeanor. The evidentiary nexus between demeanor and sanity is relatively weak.

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[24] Such a trial might be unlawful. *See* 18 U.S.C. § 4241(a); *Godinez*, 509 U.S. at 396; *Drope v. Missouri*, 420 U.S. 162 (1975); *Pate v. Robinson*, 383 U.S. 375 (1966); *see* Pet. App. 7 ("The government may not constitutionally bring an incompetent defendant to trial * * *.").

At the same time, other evidence diminishes any adverse effect from the absence of an unmedicated demeanor and more reliably addresses the issue of insanity at the time of the offense. The jury may be educated, by the judge or by expert witnesses, about the fact that the defendant is taking medication and why he may not "appear psychotic." The defendant may be videotaped in an unmedicated state close in time to the offense. Psychiatric experts and other witnesses will often provide more reliable evidence about the defendant's state of mind at the time of the offense. *See also Weston*, 255 F.3d at 884-85 (a defendant has no general right "to replicate on the witness stand his mental state at the time of the crime," giving examples of intoxication and heat of passion). The constitutional analysis of administration of needed medication, in sum, should not be altered for insanity-defense cases.

CONCLUSION

Antipsychotic medications should be treated no differently from other medications. When medically appropriate (based on a benefit-risk balance), and reasonably likely and reasonably needed to restore competence, such medication may constitutionally be compelled for that purpose in a case involving a serious enough offense.

Respectfully submitted,

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No. 02-5664

In the Supreme Court of the United States

CHARLES THOMAS SELL, PETITIONER

v.

UNITED STATES OF AMERICA

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

SUPPLEMENTAL BRIEF FOR THE UNITED STATES

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SUPPLEMENTAL BRIEF FOR THE UNITED STATES

This brief responds to the Court's order of February 28, 2003, directing the parties to file supplemental briefs addressing "the jurisdiction of this Court and of the Court of Appeals in this case, see *Cohen* v. *Beneficial Indus. Loan Corp.*, 337 U.S. 541 (1949)." The government submits that the court of appeals had jurisdiction over petitioner's appeal under 28 U.S.C. 1291 and the collateral order doctrine, see *Cohen*, *supra*, and that this Court has jurisdiction to review the court of appeals' decision under 28 U.S.C. 1254(1).

INTRODUCTION

In this case, petitioner challenged in the court of appeals the order of the district court affirming the magistrate judge's ruling that "substantive due process does not preclude the forcible administration of anti-psychotic medications to [petitioner] in this case." J.A. 339. As a result of the district court's decision, the government was entitled to seek the restoration of petitioner's competence to stand trial by administering medically appropriate antipsychotic drugs. The district court stayed its order for 14 days pending the

filing of a notice of appeal, J.A. 355, and the court of appeals later continued that stay, see Docket Entries for 4/17/02 and 3/18/02, No. 01-1862 (8th Cir.). In the court of appeals, petitioner relied on the collateral order doctrine for jurisdiction. Pet. C.A. Br. vii. The government did not challenge that assertion, and the court of appeals affirmed without discussion of jurisdiction. J.A. 356-382.

Petitioner's challenge has two elements. First, petitioner raises a substantive due process and First Amendment claim that an order of involuntary medication would violate his rights to bodily integrity, liberty, freedom of thought, and privacy. Pet. Br. 24-43; Pet. C.A. Br. 24-32. Second, petitioner contends that an order of involuntary medication would violate his fair trial rights under the Fifth and Sixth Amendments. Pet. Br. 43-50; Pet. C.A. Br. 48-50. To the extent that petitioner is challenging the government's authority to administer antipsychotic medication under substantive due process and First Amendment principles, his appeal is properly brought under the collateral order doctrine. To the extent that petitioner asserts that, if he were restored to competence through antipsychotic medication and brought to trial, the trial would violate his fair trial rights, the district court did not reach a final decision on that issue, and the collateral order doctrine is inapplicable. See J.A. 351-352 (district court explains that the issue of possible "prejudice [to] the defense at trial" from the effects of medication is a "serious issue," but "[t]he issue is, in effect, premature. Until [petitioner] is treated with anti-psychotic medication, its effects on his demeanor cannot reasonably be assessed. * * * [T]he Court here states that if medication is administered and the defense presents argument and evidence concerning its adverse effect on [petitioner's] ability to defend himself, the Court will give the issue careful consideration.").

ARGUMENT

THE COURT OF APPEALS HAD JURISDICTION UNDER THE COLLATERAL ORDER DOCTRINE

Congress has given the courts of appeals jurisdiction over "final decisions of the district courts." 28 U.S.C. 1291. Congress has also authorized this Court to review by writ of certiorari cases "in" the court of appeals. 28 U.S.C. 1254(1). See *Hohn* v. *United States*, 524 U.S. 236, 246-247 (1998). Generally, a "final decision[]" requires that the district court have entered an order that concludes the litigation "and leaves nothing for the court to do but execute the judgment." *Van Cauwenberghe* v. *Biard*, 486 U.S. 517, 521 (1988). "In criminal cases," the final judgment rule "prohibits appellate review until after conviction and imposition of sentence." *Midland Asphalt Corp.* v. *United States*, 489 U.S. 794, 798 (1989). Nevertheless, in *Cohen* v. *Beneficial Industrial Loan Corp.*, 337 U.S. 541 (1949), this Court recognized that Section 1291 should be applied in a practical manner and that some rulings of a district court constitute "final decisions" even if they are not "final judgments." *Stack* v. *Boyle*, 342 U.S. 1, 12 (1951) (Jackson, J., concurring) ("While a final judgment always is a final decision, there are instances in which a final decision is not a final judgment."). As each of the courts of appeals that has addressed the issue has concluded, an order authorizing the government to administer antipsychotic medication in order to render a defendant competent to stand trial fits within the collateral order doctrine, because it resolves an issue—whether the government may overcome the defendant's constitutional interests in resisting such an order—that finally determines an important question that is separate from the merits of the defendant's guilt or innocence on the criminal charges, and that is effectively unreviewable on appeal from a final judgment in the criminal case. U.S. Br. 10 n.5.

A. The Collateral Order Doctrine Permits Review Of Narrow Categories Of Final Decisions Before Resolution Of The Case On The Merits

In *Cohen*, this Court determined that appellate review is permitted under Section 1291 when a district court's decision before final determination of the case conclusively resolves an issue that is "too important to be denied review and too independent of the cause itself to require that appellate consideration be deferred until the whole case is adjudicated." 337 U.S. at 546. Applying that principle, *Cohen* permitted review of the question whether a state-law requirement that a plaintiff post security in a stockholder derivative action was applicable when the action was brought in federal court by virtue of diversity jurisdiction. Since *Cohen*, the rule in that case has come to be known as the collateral order doctrine, and it has been distilled into three requirements:

> To fall within the limited class of final collateral orders, an order must (1) "conclusively determine the disputed question," (2) "resolve an important issue completely separate from the merits of the action," and (3) "be effectively unreviewable on appeal from a final judgment."

Midland Asphalt Corp., 489 U.S. at 799 (quoting *Coopers & Lybrand* v. *Livesay*, 437 U.S. 463, 468 (1978)); accord, *e.g.*, *Johnson* v. *Jones*, 515 U.S. 304, 310 (1995); *Van Cauwenberghe*, 486 U.S. at 522. "The collateral order doctrine is best understood not as an exception to the 'final decision' rule laid down by Congress in § 1291, but as a 'practical construction' of it." *Digital Equip. Corp.* v. *Desktop Direct, Inc.*, 511 U.S. 863, 867 (1994).

The doctrine is a "narrow" one, *Digital Equip. Corp.*, 511 U.S. at 868, that is applied with particular stringency in criminal cases, *Midland Asphalt Corp.*, 489 U.S. at 799; *United States* v. *Hollywood Motor Car Co.*, 458 U.S. 263, 265 (1982) (per curiam) (policy against "piecemeal appellate

review * * * is at its strongest in the field of criminal law"); *United States* v. *MacDonald*, 435 U.S. 850, 853-854 (1978) ("The rule of finality has particular force in criminal prosecutions because 'encouragement of delay is fatal to the vindication of the criminal law.'"). This Court has recognized only three categories of decisions in criminal cases that are reviewable under the collateral order doctrine: the denial of a motion to reduce bail, *Stack* v. *Boyle*, *supra*, the denial of a motion to dismiss an indictment under the Double Jeopardy Clause, *Abney* v. *United States*, 431 U.S. 651 (1977), and the denial of a motion to dismiss under the Speech or Debate Clause, *Helstoski* v. *Meanor*, 442 U.S. 500 (1979).

B. The Decision Authorizing The Government To Administer Antipsychotic Medication In Order To Render Petitioner Competent To Stand Trial Is An Appealable Collateral Order

1. The district court conclusively determined that medication may be involuntarily administered

After a psychiatric evaluation of petitioner by the Bureau of Prisons Medical Center in Springfield, Missouri, conducted pursuant to 18 U.S.C. 4241(b), petitioner was determined to be incompetent to stand trial. As required by statute, the district court then committed petitioner to the custody of the Attorney General to be "hospitalize[d] * * * for treatment in a suitable facility * * * for such a reasonable period of time, not to exceed four months, as is necessary to determine whether there is a substantial probability that in the foreseeable future he will attain the capacity to permit the trial to proceed." 18 U.S.C. 4241(d)(1). See *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972).

In Springfield, after a hearing pursuant to 28 C.F.R. 549.43, the Bureau of Prisons determined that involuntary antipsychotic medication was necessary and appropriate in order to treat petitioner's mental illness and to restore him

to competence. J.A. 144-145, 150. Petitioner's administrative appeal of that hearing was denied. J.A. 152-157. Relying on *United States* v. *Brandon*, 158 F.3d 947 (6th Cir. 1998), petitioner sought review of the Bureau's order in the district court that had ordered petitioner committed to the custody of the Attorney General for competence restoration under 18 U.S.C. 4241(d). Docket Entry for 7/30/99 (No. 322), No. 97-CR-290-1 (E.D. Mo.). After a hearing, the magistrate judge entered an order that the "government may involuntarily medicate [petitioner] with antipsychotic drugs." J.A. 337. The district court affirmed that determination. J.A. 354-355. Those orders conclusively permitted the government to treat petitioner with antipsychotic medication. But for the stays entered by the magistrate judge, the district court, and the court of appeals, the Bureau of Prisons medical staff would have administered medication to treat petitioner's psychotic illness and to seek to restore his competency.

Petitioner asserts a substantive due process right to resist that medication. Under *Washington* v. *Harper*, 494 U.S. 210, 221-222 (1990), an individual has "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment." An order of involuntary medication with such drugs requires "a finding of overrriding justification and a determination of medical appropriateness." *Riggins* v. *Nevada*, 504 U.S. 127, 135 (1992). Although *Harper* involved a sentenced prisoner and this case involves a pretrial detainee, due process affords "at least as much protection to persons the [government] detains for trial" as it does for prisoners. *Ibid.* The order allowing the medication thus conclusively resolves that the government may override petitioner's substantive due process interests, as well as any residual First Amendment rights that petitioner may have in objection to antipsychotic medication.

In contrast, the district court's order did not conclusively resolve whether petitioner's fair trial rights would be violated by restoring his competence through antipsychotic medication. J.A. 351-353. The court took note of petitioner's arguments that antipsychotic medication would "adversely affect his ability to obtain a fair trial by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom and/or by rendering him unable or unwilling to assist counsel." J.A. 351. But the court responded that no "unfair trial" will occur if petitioner is shown to be unable to assist counsel because such a showing "would result in a continued finding that [petitioner] is not * * * competent to stand trial." J.A. 351. The court also noted that the potential for trial prejudice was a "serious issue," but consideration of it was "premature," because, until petitioner receives antipsychotic medication, its effects on his demeanor are speculative and unknowable. J.A. 351-352. The court made clear that it would continually assess issues that may arise based on claims of trial prejudice and quoted at length from the district court's opinion in *United States* v. *Weston*, 134 F. Supp. 2d 115 (D.D.C. 2001), on the appropriate procedure that a trial court should employ to monitor claims of prejudice and to take appropriate steps to prevent it. J.A. 352-353. Consequently, the district court's tentative rulings on trial prejudice are neither practically nor legally final and cannot be the subject of collateral order review. *MacDonald*, 435 U.S. at 858 (pretrial denial of a claim under the Speedy Trial Clause is not a final rejection of the issue, because the district court must assess it based on the particular facts developed at trial).

That is not to say that consideration of whether petitioner may receive a fair trial is irrelevant to the substantive due process claim, recognized in *Harper*, that petitioner may assert in objecting to the involuntary medication order. The government's interest is in restoring petitioner to com-

petence so that he may be brought to trial. The interest in achieving an adjudication of serious criminal charges is a compelling one, U.S. Br. 19-26, but that interest would not be achieved if there were no substantial probability that a fair trial could take place if petitioner were restored to competence through antipsychotic medication. The inquiry at this juncture, before treatment is carried out, is whether, if petitioner's competence is restored through antipsychotic medication, it can be reasonably expected that he can receive a fair trial. *Id.* at 11, 18, 38; see J.A. 376 ("We note that before forcibly medicating an accused, there must be evidence that he will be able to participate in a fair trial."); *United States* v. *Gomes*, 289 F.3d 71, 82 (2d Cir. 2002) (requiring a showing, *inter alia*, that "the defendant can be fairly tried while under the medication"), petition for cert. pending, No. 02-7118 (filed Oct. 22, 2002); *United States* v. *Weston*, 255 F.3d 873, 883-886 & n.8 (D.C. Cir.) (considering fair trial concerns as they relate to "the narrow tailoring aspect of [Weston's] Fifth Amendment substantive due process argument," which requires a "predictive judgment now"), cert. denied, 534 U.S. 1067 (2001). Such an inquiry necessarily considers judicial experience with antipsychotic medication, as well the medical literature and the record in the particular case, concerning the general effects of antipsychotic medication and the capacity of medical professionals and courts to address any potential for trial prejudice.

In this case, the government's "burden" to show that a fair trial can reasonably be expected "was met," J.A. 376, by evidence that attested to the feasibility of minimizing and treating side effects of the medication that might be thought to interfere with petitioner's fair trial interests. See U.S. Br. 38-40, 48-50. More specific claims of trial prejudice (for example, claims that antipsychotic medication would interfere with a "diminished capacity" defense, see Pet. Br. 43) must necessarily await the restoration of competence. Only

at that point will it be clear what side effects, if any, have occurred, what impact they may have on the defense, and what judicial remedies may be employed. J.A. 376 ("[T]he effects of the medication on [petitioner's] competency and demeanor may properly be considered once the medication is administered."); U.S. Br. 40-43.

2. The order permitting involuntary medication resolved an important issue that is separate from the merits of the criminal prosecution

In *Abney*, this Court determined that a double jeopardy claim, by its nature, "is collateral to, and separable from, the principal issue at the accused's impending criminal trial, *i.e.*, whether or not the accused is guilty of the offense charged." 431 U.S. at 659. The Court explained that, in raising a double jeopardy claim, "the defendant makes no challenge whatsoever to the merits of the charge against him. Nor does he seek suppression of evidence which the Government plans to use in obtaining a conviction." *Ibid.*

Here as well, the question whether petitioner may be involuntarily medicated is separate from the merits of his guilt or innocence on the charges against him of mail fraud, health care fraud, money laundering, attempted murder, and murder conspiracy. His claim that he may not be medicated does not challenge the government's right to bring those charges, nor does it contest the evidence that may be adduced. Rather, petitioner asserts a substantive due process liberty interest, as well as a First Amendment interest, in precluding the administration of medication. That claim is, if anything, more distinct from the merits of the criminal charges than the double jeopardy claim at issue in *Abney*. Resolution of a double jeopardy claim necessarily requires consideration of the particular legal theories against a defendant. Indeed, a collateral order appeal under the Double Jeopardy Clause has been held available even where the

claim at issue, if it had merit, would have required scrutiny of the sufficiency of the evidence—a matter far more tied to the merits than the involuntary medication order in this case. *Richardson* v. *United States*, 468 U.S. 317, 321-322 (1984) (even though the defendant's claim would require the court of appeals to "canvass" the trial evidence and was in that sense tied to the merits, the evidence review was "a necessary component of [the] separate claim of double jeopardy"; Court permitted the collateral order appeal, then rejected the double jeopardy theory on the merits). Similarly, a qualified immunity defense in a civil action has a significant relation to the merits of the complaint, but an order rejecting it on "an abstract issu[e] of law" is appealable under the collateral order doctrine, *Behrens* v. *Pelletier*, 516 U.S. 299, 313 (1996), because the defense, as an official's entitlement not to litigate the validity of a particular action, is "conceptually distinct" from the resolution of the case on the merits, *Mitchell* v. *Forsyth*, 472 U.S. 511, 527 (1985); *Behrens*, 516 U.S. at 309 n.3 ("the *Cohen* 'separability' component asks whether the question to be resolved on appeal is 'conceptually distinct' from the merits of the plaintiff's claim").

While petitioner's fair trial claim, in its specific application to the facts of this case, would "substantially overlap [with the] factual and legal issues of the underlying dispute," rendering that claim "unsuited" to Section 1291 review before trial, *Van Cauwenberghe*, 486 U.S. at 529 (finding forum non conveniens claims to fall outside of the collateral order doctrine); *MacDonald*, 435 U.S. at 859 (prejudice inquiry in a Speedy Trial claim is "intertwined" with "events at trial"), his substantive due process claim does not have such an overlap with the merits. That claim requires the determination whether the government's interest in seeking an adjudication of serious criminal charges outweighs the defendant's interest in avoiding unwanted treatment with antipsychotic medication. Determination of that issue is conceptually and factually distinct from the merits.

The strong policy against piecemeal appeals in criminal cases does not require a different conclusion. While most matters that arise during a criminal proceeding bear concretely and primarily on whether the defendant will receive a fair adjudication of the charges against him, the distinctive feature of petitioner's claim is its assertion of liberty and autonomy interests that are protected quite apart from their impact on the outcome or fairness of the trial.

The distinctness of the medication issue from the merits of the criminal prosecution is illustrated by the possibility of characterizing the defendant's challenge as a free-standing attack on the administrative decision by the Bureau of Prisons to medicate under its regulatory scheme, 28 C.F.R. 549.43(a)(5) ("When an inmate will not or cannot provide voluntary written informed consent for psychotropic medication, the inmate will be scheduled for an administrative hearing. * * * The psychiatrist conducting the hearing shall determine whether * * * psychotropic medication is necessary in order to attempt to make the inmate competent for trial."). If no other form of judicial review were available, the Administrative Procedure Act would supply the basis for review. 5 U.S.C. 703, 704.

In fact, however, judicial review by motion in the criminal case is the appropriate procedure. When a court in which a prosecution is pending determines that a defendant is incompetent to stand trial, "the court shall commit the defendant to the custody of the Attorney General," who is to "hospitalize the defendant for treatment in a suitable facility." 18 U.S.C. 4241(d). The court must also determine, after a reasonable period not to exceed four months, whether the defendant's hospitalization should continue "for an additional reasonable period" if there is a "substantial probability" that within that time he will attain competence. 18 U.S.C.

4241(d)(1) & (2). If the "director of the facility in which a defendant is hospitalized pursuant to subsection (d) determines that the defendant" has attained competency, the court has the further responsibility to "hold a hearing * * * to determine the competency of the defendant." 18 U.S.C. 4241(e).

Accordingly, the district court in the criminal case has comprehensive statutory responsibilities to determine whether treatment has a substantial probability of succeeding in restoring competence, and whether treatment, once administered, has succeeded in that goal. It is logical, both as an adjunct to that statutory responsibility and as a matter of judicial efficiency, to channel legal disputes about the appropriateness and constitutionality of involuntary medication to that district court, to be resolved within the framework for adjudicating competence issues under Section 4241, rather than to a court that is a stranger to the case or to a proceeding unrelated to the criminal prosecution.

The involuntary medication issue is also important enough to warrant appellate review at this juncture, *i.e.*, before the medication is administered. Antipsychotic medication is medically appropriate, and often indispensable, to treat the delusions, hallucinations, disordered thinking, and impaired rationality that characterizes psychotic illness. At the same time, the decision whether to administer such medication bears on significant liberty and autonomy interests. The issue is therefore important enough to warrant appellate review before a final judgment is entered.

3. The order is effectively unreviewable on appeal from a final judgment of conviction

The third component of the collateral order test requires distinguishing between (1) the aspect of petitioner's claim that asserts a substantive due process liberty interest and a First Amendment interest in avoiding involuntary medication and (2) the aspect that asserts that involuntary medication will deprive him of his Fifth and Sixth Amendment fair trial rights. The latter interests can be fully vindicated on a direct appeal from a conviction, and so do not support collateral order review. The former, however, would be "irretrievably lost," *Van Cauwenberghe*, 486 U.S. at 524, if pre-medication appellate review were not available.

In *Midland Asphalt*, the Court held that a defendant could not appeal, under the collateral order doctrine, a decision denying a motion to dismiss an indictment based on an alleged violation of grand jury secrecy under Fed. R. Crim. P. 6(e). 489 U.S. at 799-800. The Court explained that, if the Rule 6(e) violation could support reversal of the defendant's conviction on appeal, "it is obvious that [it is] not 'effectively unreviewable on appeal from a final judgment.'" *Id.* at 800 (quoting *Coopers & Lybrand*, 437 U.S. at 468).

This Court held in *Riggins* that because a particular order of involuntary medication was not properly supported by a sufficient government interest, the potential prejudice to the defendant's fair trial rights indicated by the record justified reversal of the conviction. 504 U.S. at 136-138. The Court explained that "[b]ecause the record contains no finding that might support a conclusion that administration of antipsychotic medication was necessary to accomplish an essential state policy, * * * we have no basis for saying that the substantial probability of trial prejudice in this case was justified." *Id.* at 138. Under *Riggins*, petitioner, if he is restored to competence by antipsychotic medication and convicted at trial, could raise on appeal a claim that his conviction should be reversed on the ground that antipsychotic medication was not justified or that it had an unduly prejudicial effect on his trial. Such a claim, if upheld on appeal, would entirely vindicate his fair trial rights under the Fifth and Sixth Amendments. See *Hollywood Motor Car Co.*, 458 U.S. at 269-270 (claim of prosecutorial vindictiveness is

adequately vindicated by reversal on appeal and provision of a new trial); *MacDonald*, 435 U.S. at 860-861 (Speedy Trial claim can be vindicated by reversal of conviction on appeal).

Review of the involuntary medication order at the conclusion of the case, however, would not vindicate petitioner's substantive due process interests. If petitioner were acquitted, he would not be able to appeal at all. And even if petitioner were convicted, review would come too late to prevent the intrusion on his liberty that petitioner claims is unjustified. The interest of petitioner in avoiding unwanted medication is lost when the medication is administered. Similarly, any constitutionally protected interest under the First Amendment cannot be vindicated after trial. As the Court has observed, the "effectively unreviewable" component of the collateral order test considers whether the order in question implicates "an asserted right the legal and practical value of which would be destroyed if it were not vindicated before trial." *MacDonald*, 435 U.S. at 860. The order in this case satisfies that test.

It is not essential to the availability of a collateral order appeal that the defendant's underlying legal claim involve a right not be tried at all, as was the case in *Abney* and *Helstoski*. In *Stack* v. *Boyle*, the Court held that a motion to reduce bail is appealable at the time of its entry. As Justice Jackson explained in his concurrence in *Stack*, unless a order fixing bail "can be reviewed before sentence, it never can be reviewed at all." 342 U.S. at 12 (concurring opinion). Although review of bail orders is now explicitly permitted by statute, see 18 U.S.C. 3145, 3731, the reasoning underlying *Stack*'s collateral order holding is equally applicable to the substantive due process interest at stake here as well. The liberty interest in remaining at large pending trial cannot be vindicated on appeal from a final judgment. Likewise, the liberty interest in avoiding unwanted antipsychotic medication must be vindicated before the medication is administered, or not at all. That consideration satisfies the third requirement of the collateral order test. Cf. *Abney*, 431 U.S. at 662 ("[I]f a criminal defendant is to avoid *exposure* to double jeopardy and thereby enjoy the full protection of the Clause, his double jeopardy challenge to the indictment must be reviewable before that subsequent exposure occurs.").

C. Permitting Collateral Order Review In This Case Does Not Imply That All Involuntary Medication Orders Are Subject To Plenary Review Under The *Cohen* Rule

1. Delay in collateral order appeals can have significant consequences

Review of the involuntary medication order in this case has caused significant delay in the efforts to treat petitioner in order to restore him to competence. Such delay has served neither the government's nor petitioner's interests. The delay has frustrated the government's interest in adjudicating serious criminal charges, and it has the potential to prevent adjudication of those charges at all. After the elapse of the initial four-month period of hospitalization under 18 U.S.C. 4241(d)(1), a district court can continue a person's hospitalization for "an additional reasonable period of time," provided that the court finds that there is a "substantial probability" that the defendant "will attain the capacity to permit the trial to proceed." 18 U.S.C. 4241(d)(2); see 18 U.S.C. 4247(e)(1)(A) (requiring the director of the facility in which a person is hospitalized under Section 4241 to "prepare semiannual reports" for the court that ordered the person's commitment). To date, based on the opinion of the Bureau of Prisons medical professionals that petitioner's competence can be restored through antipsychotic medication, the government has periodically requested that the district court continue petitioner's hospitalization. But the longer that an individual with delusional disorder goes untreated, the greater the possibility that antipsychotic medi-

cation may be ineffective when administered. See J.A. 165, 216. Postponing treatment may therefore prevent the restoration of competency at all. In addition, "delay may prejudice the prosecution's ability to prove its case, increase the cost to society of maintaining those defendants subject to pretrial detention," *MacDonald*, 435 U.S. at 862, and preclude closure for the victims of the offenses—an especially acute concern where, as here, a defendant is charged with trying to arrange the murder of a government agent and a prosecution witness.

The delay does not inure to petitioner's benefit either. While this appeal has been pending, petitioner has been hospitalized in a Bureau of Prisons medical center without any opportunity to resolve the criminal charges against him. Hospitalization without treatment also may impair petitioner's medical interests in having his delusional disorder effectively treated. There is no sound basis for believing that any treatment other than antipsychotic drugs will be effective, and there is no reason to believe that petitioner's condition will spontaneously improve to the point where he will regain competence.

The process of appellate review necessarily requires a certain degree of delay, and that is a concern in any case in which the collateral order doctrine applies. *Richardson*, 468 U.S. at 322. Those concerns are offset to some extent by the interest in safeguarding an important right that would otherwise evade review, and by the fact that the appeal here, as in *Richardson*, did not "interrupt or delay proceedings during the time that a jury was empaneled." *Ibid.* Nevertheless, the concerns arising from appellate delay are real.

2. Reasonable steps can minimize delay in future cases.

If this Court rules that involuntary antipsychotic medication to restore competence can be ordered based on an appropriate showing, there are measures that can and should be employed in future cases to avoid undue delay from collateral order review.

First, the central issue in this case is whether petitioner may be medicated at all consistent with his substantive due process and First Amendment rights, when the government has brought non-violent felony charges. J.A. 384 (order granting certiorari). This Court's resolution of that legal issue, if it strikes the balance in favor of permitting medication based on an appropriate showing, will remove that issue from the realm of legal claims that can support a collateral order appeal. In *Richardson*, for example, the Court entertained a collateral order appeal to resolve the question whether the Double Jeopardy Clause required a court, after granting a mistrial when the jury has been unable to return a verdict, to determine whether the government's evidence was sufficient to convict. The Court rejected that claim on the merits. It then stated that "[i]t follows logically from our holding today that claims of double jeopardy such as petitioner's are no longer 'colorable' double jeopardy claims which may be appealed before final judgment." 468 U.S. at 326 n.6. Similarly, to the extent that the decision in this case resolves the overarching constitutional issue, an appeal to relitigate that holding would be not be colorable.

Second, future appeals addressed to the specific application of a general legal rule permitting involuntary treatment with antipsychotic medications in order to restore a defendant to competence can and should be dealt with in a more summary fashion than the appeal in this case. To the extent that a defendant in such a case challenges the factual findings of the district court as clearly erroneous, review can be conducted expeditiously and without undue taxing of appellate resources. To the extent that the defendant challenges the lower court's exercise of discretion, review can be similarly abbreviated, assuming that collateral order review

is available at all. Cf. *Stack*, 342 U.S. at 6 (distinguishing between motions to reduce bail that "invoke[d] the discretion of the District Court setting bail within a zone of reasonableness" and motions that challenged the bail order on statutory and constitutional grounds, and expressing no view on collateral order appeals of the former class); *Cohen*, 337 U.S. at 547 ("If the right were admitted or clear and the order involved only an exercise of discretion as to the amount of security, a matter the statute makes subject to reconsideration from time to time, appealability would present a different question."). And to the extent that a defendant brings only plainly unfounded objections to an order of involuntary medication, "[i]t is well within the supervisory powers of the courts of appeals * * * to weed out frivolous claims." *Behrens*, 516 U.S. at 310 (quoting *Abney*, 431 U.S. at 662 n.8).

All of these considerations should allow courts of appeals to give "expedited treatment" to future collateral order appeals from orders of involuntary medication. *Abney*, 431 U.S. at 662 n.8; cf. *United States* v. *Weissberger*, 951 F.2d 392, 397 (D.C. Cir. 1991) (noting the possibility of special panels to give expedited treatment to appeals from orders requiring hospitalization of a defendant for a competency examination under 18 U.S.C. 4241(b)). In addition, collateral order appeals may be further streamlined by requiring defendants to meet the normal requirements for a stay of the order permitting involuntary medication, including a likelihood of success on the merits. See Fed. R. App. P. 8; *Hilton* v. *Braunskill*, 481 U.S. 770, 776 (1987). In this case, in light of the important and unresolved legal issues, the government did not oppose stays of the orders of the magistrate judge, the district court, and the court of appeals. In future cases, assuming that this Court were to approve treatment orders and to lay down guidelines for the showing that must be made, stays (which delay resolution of the criminal case

and may impair the defendant's course of treatment) will often be unwarranted. That would be particularly true if a defendant were to resist medication for the first time while the trial is in progress, thus disrupting ongoing proceedings. Cf. *Hilton*, 481 U.S. at 776 (noting that a traditional stay factor is "whether issuance of the stay will substantially injure the other parties interested in the proceeding").

Finally, there is no reason to think that collateral order appeals in future cases will place an unwarranted burden on federal appellate courts or will unduly disrupt criminal prosecutions. The universe of patients who are treated involuntarily with antipsychotic medication is relatively small. As the government noted, U.S. Br. 27-28, in a recent 12-month period, of the 285 patients treated after hospitalization for incompetence to stand trial under 18 U.S.C. 4241(d), nearly 80% accepted treatment voluntarily, and it does not appear that, of the remaining 59 patients who were treated involuntarily, any large number sought judicial review. The fact that antipsychotic medication is in the medical interest of those patients no doubt accounts for the limited number of legal appeals pursued, and that consideration should further reduce any concerns about recognizing collateral order appeals in this context. Cf. *Behrens*, 516 U.S. at 310 (noting that successive qualified immunity appeals "seem to be a rare occurrence").

CONCLUSION

The court of appeals had jurisdiction under 28 U.S.C. 1291 and the collateral order doctrine to the extent that petitioner challenges the order of the district court authorizing involuntary medication with antipsychotic drugs on substantive due process and First Amendment grounds, and this Court has jurisdiction under 28 U.S.C. 1254(1).

Respectfully submitted.

THEODORE B. OLSON
Solicitor General

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In The

Supreme Court of the United States

CHARLES THOMAS SELL, D.D.S.,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

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INTRODUCTION

Petitioner Dr. Charles Thomas Sell submits this Supplemental Brief in response to the Court's Order of February 28, 2003 directing the parties to file supplemental briefs addressing "the jurisdiction of this Court and of the Court of Appeals in this case, see *Cohen v. Beneficial Industrial Loan Corp.*, 337 U.S. 541 (1949)." In accord with the government, Dr. Sell submits that the Court of Appeals had jurisdiction under 28 U.S.C. § 1291 pursuant to the collateral order doctrine and that this Court has jurisdiction under 28 U.S.C. § 1254(1).

ARGUMENT

THE COURT OF APPEALS HAD JURISDICTION BECAUSE THE ORDER OF THE DISTRICT COURT AUTHORIZING THE GOVERNMENT TO FORCIBLY MEDICATE DR. SELL SOLELY FOR THE PURPOSE OF PENDERING HIM COMPETENT TO STAND TRIAL CONSTITUTES A "FINAL DECISION" UNDER SECTION 1291 AS THAT TERM IS CONSTRUED PURSUANT TO THE COLLATERAL ORDER DOCTRINE.

Jurisdiction in this Court is proper pursuant to Section 1254(1),[1] which provides that cases in the courts of appeals may be reviewed by the Supreme Court by writ of certiorari. This Court properly granted a writ of certiorari on November 4, 2002. 123 S. Ct. 512. This case was properly in the United States Court of Appeals for the Eighth Circuit pursuant to Section 1291, which provides that the courts of appeals "*shall* have jurisdiction of appeals from all *final decisions* of the district courts of the United States. . . . " (emphasis added). The Court of Appeals had jurisdiction because the District Court order authorizing

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[1] Unless otherwise indicated, all section citations are to Title 28 of the United States Code.

the government to forcibly medicate Dr. Sell with antipsychotic drugs solely for the purpose of rendering him competent to stand trial constitutes a final decision.

Generally, a final decision requires a district court order concluding the litigation, which, in criminal cases, usually takes the form of a conviction and imposition of sentence. *Midland Asphalt Corp. v. United States*, 489 U.S. 794, 798 (1989). However, in the case of *Cohen v. Beneficial Indus. Loan Corp.*, 337 U.S. 541 (1949), this Court recognized that Section 1291 does not limit appellate jurisdiction to "those final judgments which terminate an action." *Id.* at 545. Instead, the term "final decision" was to be given a "practical rather than a technical construction." *Id.* at 546; *see also Digital Equip. Corp. v. Desktop Direct, Inc.*, 511 U.S. 863, 867 (1994) ("The collateral order doctrine is best understood not as an exception to the 'final decision' rule . . . but as a 'practical construction' of it. . . . ") (citations omitted).[2] In accord with this practical construction to be given to Section 1291, the *Cohen* court recognized a small class of district court decisions that, though short of final judgment, are final decisions that are immediately appealable because they "finally determine claims of right separable from, and collateral to, rights asserted in the action, too important to be denied review and too independent of the cause itself to require that appellate consideration be deferred until the whole case is adjudicated." 337 U.S. at 546. To fall within the limited class of final collateral orders, an order must (i) "conclusively determine the disputed question," (ii) "resolve an important issue completely separate from the merits of the action," and (iii) "be effectively unreviewable on appeal from a final judgment." *Coopers & Lybrand v.*

[2] As Justice Jackson, the author of *Cohen*, later recognized: "[I]t is a final *decision* that Congress has made reviewable. . . . While a final judgment always is a final decision, there are instances in which a final decision is not a final judgment." *Stack v. Boyle*, 342 U.S. 1, 12 (1951) (separate opinion).

Livesay, 437 U.S. 463, 468 (1978) (footnote omitted). The order at issue here satisfies the collateral order doctrine requirements.

A. The District Court's Order Falls Squarely Within This Recognized Class of Final Decisions and Represents a Narrow Application of, Not an Extension of, the Collateral Order Doctrine.

While the collateral order doctrine is strictly interpreted in criminal cases, *Midland Asphalt*, 489 U.S. at 799, this Court has recognized three examples of pretrial orders in criminal cases that constitute final decisions under the collateral order doctrine: the denial of a motion to reduce bail, *Stack*, 342 U.S. at 4-5, denial of a motion to dismiss an indictment under the Double Jeopardy Clause, *Abney v. United States*, 431 U.S. 651 (1977), and denial of a motion to dismiss under the Speech or Debate Clause, *Helstoski v. Meanor*, 442 U.S. 500 (1979).

Although this Court has not squarely addressed the appealability of the order at issue here, every court of appeals to address the issue, including by implication the court of appeals below (J.A. 356-82), has uniformly held that an order approving the involuntary medication of a pretrial detainee constitutes an appealable collateral order under *Cohen*. *See United States v. Gomes*, 289 F.3d 71, 79 (2d Cir. 2002), *petition for cert. pending*, No. 02-7118 (filed October 22, 2002); *United States v. Morgan*, 193 F.3d 252, 258-59 (4th Cir. 1999); *United States v. Brandon*, 158 F.3d 947, 950-51 (6th Cir. 1998); *see also United States v. Weston*, 255 F.3d 873 (D.C. Cir. 2001) (exercising, without expressly considering the issue, appellate jurisdiction over a district court order authorizing the involuntary medication of a criminal defendant to render him competent to stand trial); *cf. United States v. Weissberger*, 951 F.2d 392, 396 (D.C. Cir. 1991) (holding court had jurisdiction under *Cohen* to review order permitting involuntary confinement for competency examination under 18 U.S.C. § 4241(a)). While parties cannot consent to jurisdiction,

the government agrees with the holdings of these courts of appeals. (Gov't Brief at 10 n.5).

1. The order conclusively determined the disputed question, namely whether the government could forcibly medicate Dr. Sell with antipsychotic drugs solely for the purpose of attempting to render him competent to stand trial for non-violent offenses.

To fall within the collateral order doctrine, the order must "conclusively determine the disputed question." *Coopers & Lybrand*, 437 U.S. at 468. In holding that a pretrial order denying a criminal defendant's motion to dismiss premised upon a double jeopardy claim satisfied this requirement, this Court explained:

> [T]here can be no doubt that such orders constitute a complete, formal, and, in the trial court, final rejection of a criminal defendant's double jeopardy claim. There are simply no further steps that can be taken in the District Court to avoid the trial the defendant maintains is barred by the Fifth Amendment's guarantee.

Abney, 431 U.S. at 659; *see also Richardson v. United States*, 468 U.S. 317, 321-22 (1984).

The order at issue in this case is no different. Once the District Court affirmed the Magistrate Judge's order authorizing the forcible administration of antipsychotic medication to Dr. Sell in an attempt to render him competent for trial, the decision was final. Dr. Sell could take no further steps in the District Court to avoid the forced administration of antipsychotic drugs. The District Court recognized as much in further ordering that "the magistrate judge's order permitting the involuntary administration of antipsychotic medication to defendant Charles Sell is stayed for fourteen (14) days to permit defendant to take an appeal from this ruling." (J.A. 355). But for stays of the order, the Bureau of Prisons would have already forcibly medicated Dr. Sell against his will.

Thus, the question of whether Dr. Sell can be medicated without violating his Fifth and First Amendment rights has been conclusively determined by the District Court. As the government itself acknowledges, a hearing was required upon Dr. Sell's claim that he could not be forcibly medicated. (Gov't Supp. Br. at 2). Further, the government agrees that whether and to what extent Dr. Sell could receive a fair trial after being forcibly medicated with antipsychotic drugs is directly relevant to whether the government's interest in attempting to render him competent to stand trial for non-violent charges can justify the infringement of his fundamental liberty interests secured by the First and Fifth Amendments.[3] (Gov't Supp. Br. at 7-8) (citing, *inter alia*, *Gomes*, 289 F.3d at 82 (requiring a showing that "the defendant can be fairly tried while under the medication" before forcible medication could be allowed); *Weston*, 255 F.3d at 883-86 & n.8 (recognizing that fair trial concerns should be considered in assessing the accused's "Fifth Amendment substantive due process argument," noting that such analysis requires a "predictive judgment now"); Reply Br. of Petitioner at 19 (explaining that "a predeprivation review of Dr. Sell's Fifth and Sixth Amendment trial rights is vital to the consideration of whether the government's interest in overriding Dr. Sell's First and Fifth Amendment rights is compelling"). If the validity of the very trial that provides the

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[3] To the extent that this Court finds that consideration of Dr. Sell's Fifth and Sixth Amendment trial rights is not required in connection with a First and Fifth Amendment substantive analysis, an examination of whether Dr. Sell is entitled to a premedication hearing before deprivation of his Fifth and Sixth Amendment trial rights, and the standards to be applied at such a hearing, are likewise reviewable under the collateral order doctrine for the same reasons articulated herein. *See Riggins v. Nevada*, 504 U.S. 127, 143-44 (1992) (Kennedy, J., concurring) (recognizing that trial prejudice must be considered before medication). Without a pre-medication review of the effects of antipsychotic drugs upon Dr. Sell's trial rights and defenses, there will be no baseline against which to compare the post-medication results. Post-judgment appeal would be ineffective in preserving these interests.

government's sole purpose for forcibly medicating Dr. Sell will be fraught with procedural infirmities, then the government's interest in pursuing this suspect process is greatly diminished. The failure to properly consider the unfairness of any potential trial that might be made possible only through the forcible administration of antipsychotic medication is further evidence of the violation of Dr. Sell's First and Fifth Amendment substantive rights and the improper standard applied by the District Court and the Court of Appeals.

2. Determining whether the government can forcibly medicate a citizen, presumed to be innocent, with antipsychotic drugs solely for the purpose of rendering him competent to stand trial for non-violent offenses is an important issue completely separate from the merits of the underlying indictment.

The next requirement under the collateral order doctrine is that the order must "resolve an important issue completely separate from the merits of the action." *Coopers & Lybrand*, 437 U.S. at 468. The merits of the underlying non-violent indictment focus on whether Dr. Sell was guilty or not guilty of mail fraud, healthcare fraud, and money-laundering. The order at issue before this Court has absolutely nothing whatsoever to do with Dr. Sell's guilt or innocence. An entirely separate evidentiary hearing was held for the exclusive purpose of determining whether the government could forcibly medicate Dr. Sell with antipsychotic drugs. (J.A. 159-60). As such, the District Court's order satisfies the completely separate requirement.

The District Court's order is far more removed from the merits of the underlying litigation than many other pretrial orders that this Court has found appealable under the collateral order doctrine. *See Richardson*, 468 U.S. at 321-22; *Behrens v. Pelletier*, 516 U.S. 299, 309-11 (1996) (holding that, despite prior appeal, denial of summary judgment on grounds of qualified immunity was

appealable pursuant to the collateral order doctrine). For example, in *Richardson*, the government argued that "resolution of the double jeopardy claim inevitably involves evaluation of the sufficiency of the evidence against petitioner at the first trial, and therefore the claim is not completely collateral to the merits of the charge against petitioner." 468 U.S. at 321. The government went on to explain that the district court's "canvassing of the record would be indistinguishable from an assessment of the sufficiency of the evidence that would be reviewed after a judgment of conviction, and, of course, would go to the heart of the Government's case on the merits." *Id.* While acknowledging that "[a]ll of this may be conceded," this Court nevertheless reasoned "we think that the collateral-order doctrine applied in *Abney* should not be read so narrowly as to bar from interlocutory review the type of double jeopardy claim asserted here." *Id.* at 321-22. Because the petitioner in *Richardson* sought review of the sufficiency of the evidence at his first trial, not to reverse a judgment entered on that evidence, but as a necessary component of the separate claim of double jeopardy, this Court held that the district court's order denying petitioner's double jeopardy claim was appealable under the collateral order doctrine. *Id.*

Unlike the order at issue in *Richardson*, the order here had no overlap with the merits of the case. The evidence introduced at the magistrate judge's evidentiary hearing had nothing to do with Dr. Sell's guilt or innocence. Instead, the evidence introduced at the hearing included testimony pertaining to, among other things, the side effects caused by antipsychotic medication, whether these drugs would achieve their goal of rendering Dr. Sell competent to stand trial, and Dr. Sell's alleged dangerousness in an institutional setting. (J.A. 158-319). None of this evidence required a review of the merits of the underlying charges.

Similarly, this case addresses an important issue: whether the government has the authority to medicate a citizen with antipsychotic drugs against his will to attempt to prosecute him for non-violent charges. This Court has

recognized that "[w]here statutory and constitutional rights are concerned, 'irretrievable loss' can hardly be trivial." *Digital Equip.*, 511 U.S. at 879. Dr. Sell submits that the involuntary administration of antipsychotic drugs to a citizen implicates the most fundamental of liberty interests. The right to be free from unwanted physical and mental intrusions has long been recognized as an integral part of an individual's constitutional freedom, and such rights having been articulated under the First Amendment as freedom of thought, right to refuse unwanted medical treatment or right to privacy, under the Fifth Amendment Due Process Clause as a liberty interest or right to privacy, and as an aspect of the "right to privacy contained in the notions of personal freedom which underwrote the Bill of Rights." *United States v. Charters*, 829 F.2d 479, 491 (4th Cir. 1987); *see also Stanley v. Georgia*, 394 U.S. 557, 565 (1969) (recognizing First Amendment privacy interest); *Roe v. Wade*, 410 U.S. 113, 152-53 (1973) (citing various sources of right to privacy); *Planned Parenthood v. Casey*, 505 U.S. 833, 852 (1992) (recognizing fundamental right for woman to have abortion); *Griswold v. Connecticut*, 381 U.S. 479, 482-86 (1965) (recognizing right to use contraceptives is fundamental); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990).

The fundamental liberty interests implicated by the District Court's order cannot be said to be any less important than other issues that this Court has found satisfied the collateral order requirements, such as avoiding the burdens of pretrial discovery in violation of a defendant's qualified immunity claim, *Behrens*, 516 U.S. at 308, a criminal defendant's interest in avoiding trial pursuant to a double jeopardy or Speech or Debate Clause defense, *Abney*, 431 U.S. at 659-62, *Helstoski*, 442 U.S. at 506-08, or a criminal defendant's interest in reducing bail, *Stack*, 342 U.S. at 6-7. For example, an accused's interest in avoiding "the personal strain, public embarrassment, and expense of a criminal trial" was important enough to justify a collateral order doctrine appeal. *Abney*, 431 U.S. at 661. Mere personal strain, public embarrassment, and expense are less important than the physical and mental

intrusion implicated by the involuntary administration of antipsychotic drugs.

3. The order at issue here would be effectively unreviewable on appeal from a final judgment in that the legal and practical value of Dr. Sell's fundamental right not to be forcibly medicated with antipsychotic drugs solely for the purpose of rendering him competent to stand trial would be destroyed if it were not vindicated before trial.

The third and final collateral order requirement is that the order "be effectively unreviewable on appeal from a final judgment." *Coopers & Lybrand*, 437 U.S. at 468. This third prong is satisfied "where the order at issue involves 'an asserted right the legal and practical value of which would be destroyed if it were not vindicated before trial.'" *Midland Asphalt*, 489 U.S. at 799 (quoting *United States v. MacDonald*, 435 U.S. 850, 860 (1978)). In other words, an order is effectively unreviewable "when the practical effect of the order will be *irreparable* by any subsequent appeal." *Di Bella v. United States*, 369 U.S. 121, 126 (1962) (emphasis added); *see also Abney*, 431 U.S. at 658 (explaining that the third element requires that the right "would be 'lost, probably *irreparably*,' if review had to await final judgment").

The right at issue here is Dr. Sell's fundamental constitutional right not to be medicated against his will with antipsychotic drugs solely for the purpose of attempting to render him competent to stand trial for non-violent offenses. As an initial matter, and as the government also recognizes, if Dr. Sell were acquitted in the underlying criminal action, he would not be able to appeal.[4]

[4] This issue is important to Dr. Sell because he has refused the administration of antipsychotic drugs, even though he has already been imprisoned longer than he would have been if convicted of the

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Regardless, even if he were convicted and obtained appellate review of the issue, such review would not be "effective" because "the legal and practical value" of his right not to be forcibly medicated with antipsychotic drugs with potentially permanent physical and mental side effects would have already been irretrievably lost. *See Abney*, 431 U.S. at 662 ("[E]ven if the accused is acquitted, or, if convicted, has his conviction ultimately reversed on double jeopardy grounds, he has still been forced to endure a trial that the Double Jeopardy Clause was designed to prohibit."). Even more so than the right at issue in *Abney*, no amount of *post hoc* appellate review can vindicate Dr. Sell's fundamental right not to be forcibly medicated after the forced medication takes place. *See Gomes*, 289 F.3d at 79 ("If the defendant should prevail after he has been forcibly medicated, his right to refuse to be medicated would have been lost and his victory would be a hollow one.").

This Court has recognized that a detainee's right to reduce bail so as to remain free pending a trial is a right that cannot be vindicated on appeal from a final judgment. *Stack*, 342 U.S. at 12 (concurring opinion). Similarly, this Court has found that the right to "avoid exposure to double jeopardy and thereby enjoy the full protection of the [Double Jeopardy] Clause" satisfies this requirement. *Abney*, 431 U.S. at 662. Even the denial of a motion to dismiss on grounds of qualified or absolute immunity is subject to immediate appeal. *See Puerto Rico Aqueduct & Sewer Auth. v. Metcalf & Eddy, Inc.*, 506 U.S. 139, 143-44 (1993) (holding that Eleventh Amendment immunity claim is subject to immediate appeal and recognizing that, in *Mitchell v. Forsyth*, 472 U.S. 511 (1985), this Court "found

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non-violent charges. Further, Justices of this Court have recognized that while direct appeal is an appropriate remedy for determining whether a conviction was proper, direct appeal does not provide a remedy for other constitutional violations. *Riggins*, 504 U.S. at 156 (Thomas, J., dissenting).

that, absent immediate appeal, the central benefits of qualified immunity – avoiding the costs and general consequences of subjecting public officials to the risks of discovery and trial – would be forfeited, much as the benefit of the bond requirement would have been forfeited in *Cohen*"). At a minimum, a citizen's right to refuse unwanted antipsychotic medication – sought to be administered solely for the purpose of rendering him competent to stand trial on non-violent charges – presents an even more compelling example.

Nor should this case be rejected through conjecture that Dr. Sell might have initiated a separate proceeding to vindicate his constitutional rights. As an initial matter, it does not appear that Dr. Sell could have obtained effective relief through any separate proceeding. Dr. Sell could not have stated a cognizable claim under 42 U.S.C. § 1983 because the "actors" seeking to medicate Dr. Sell were not state actors, but rather the United States Bureau of Prisons. *See* 42 U.S.C. § 1983 (by its very terms, § 1983 precludes liability against federal government actors); *see also Martin v. Sias*, 88 F.3d 774, 775 (9th Cir. 1996). Nor could a *Bivens* action provide adequate relief to Dr. Sell. From the outset, an opinion in this case is necessary to set forth the law as it pertains to the involuntary administration of antipsychotic drugs to pretrial detainees. *Bivens v. Six Unknown Named Agents of Fed. Bureau of Narcotics*, 403 U.S. 388 (1971). Prior to the determination, the federal actors who seek to forcibly medicate Dr. Sell would likely assert and obtain qualified immunity, as the constitutional requirements governing forced medication of pretrial detainees will not be clearly established law. *See Saucier v. Katz*, 533 U.S. 194, 201 (2001). Further, even if Dr. Sell could obtain a final judgment in the separate *Bivens* action, it is not at all clear that he could have obtained a stay in the criminal proceeding prohibiting medication until the completion of the *Bivens* action. In addition, Dr. Sell would be additionally prejudiced by being relegated to a *Bivens* action to vindicate his constitutional rights because he would not be constitutionally

entitled to appointed counsel. *See* 28 U.S.C. § 1915(e)(1) (permitting court to appoint counsel at its discretion).

Most importantly, an accused should not be forced to wade through a procedural quagmire in order to protect fundamental liberty interests secured by the Constitution. No such procedural second-guessing took place in *Abney* or *Richardson* in securing an accused's rights under the Double Jeopardy Clause. As the government recognized, judicial review by motion in the criminal case is the appropriate procedure because the District Court has comprehensive statutory responsibilities to assess treatment bearing upon an accused's competence to stand trial. (Gov't Supp. Br. at 11-12 (citing 18 U.S.C. § 4241)). The District Court has made such an assessment and ordered that Dr. Sell be subjected to 18 U.S.C. § 4241 from which now arises the order at issue. (J.A. 320-38). Moreover, forcing a criminal defendant to initiate a separate civil proceeding to overturn an order issued by a district court in the course of a criminal proceeding would not serve the interests sought to be preserved by the "final decision" rule. Encouraging such fragmented proceedings would do more violence to the undergirding objective of judicial economy than allowing the collateral order appeal process followed here.

Similarly, given the uniform holdings of the courts of appeals that such an order is subject to review pursuant to the collateral order doctrine, Dr. Sell could not, in good faith, challenge the order through proceedings by mandamus. *See Helstoski*, 442 U.S. at 505 ("The general principle which governs proceedings by mandamus is, that whatever can be done without the employment of that extraordinary writ, *may not be done with it*. It lies only when there is practically *no other remedy*.") (quoting *Ex parte Rowland*, 104 U.S. 604, 617 (1882)). Indeed, in *Helstoski*, this Court held that, because a criminal defendant could challenge a pretrial order denying his motion to dismiss pursuant to the Speech or Debate Clause of the United States Constitution pursuant to the collateral order doctrine, mandamus was an inappropriate means of challenging the order and declined to address the merits.

Id. at 507-08. The Court reached this conclusion despite the fact that the Supreme Court had never before held that such an order fell within the contours of the collateral order doctrine. *Id.* at 509 n.* ("The Court makes the surprising assertion that Helstoski should have anticipated today's holding on the basis of a footnote in a 1975 Third Circuit opinion dealing with a different issue.") (Brennan, J., dissenting). Thus, given that every court of appeals to address the issue had already indicated the order was appealable, Dr. Sell could not reasonably have premised such a challenge upon a proceeding by mandamus. Dr. Sell's case should not be denied review for having relied upon the uniform decisions of the courts of appeals.

Both the practical reality of the manner within which this issue arose as well as sound notions of judicial efficiency demonstrate that judicial review in the criminal case is the appropriate procedure. Further, the legal and practical value of Dr. Sell's fundamental liberty interest in not undergoing forced administration of antipsychotic drugs is destroyed once the drugs are administered. These rights cannot be returned through any form of post-medication, post-judgment review. As such, the District Court's order constitutes a final decision appealable pursuant to the collateral order doctrine.

B. The Collateral Order Doctrine Is Not an Extra-Statutory Right to Appellate Review But, Rather, a Practical Statutory Interpretation of Section 1291; Moreover, Its Application to the Order at Issue Here Would Not Result in a Rash of Frivolous Appeals Undermining the Objectives of the Final Decision Rule.

The collateral order doctrine represents a practical statutory interpretation of what is meant by "final decision" in Section 1291. *See, e.g., Cohen*, 337 U.S. at 546; *Digital Equip. Corp.*, 511 U.S. at 867. This must be the case for there is no right to appeal absent congressional authorization. *Martinez v. Court of Appeal of Cal., Fourth Appellate Dist.*, 528 U.S. 152 (2000) (quoting *Abney*, 431

U.S. at 656). In fact, despite approximately 54 years of collateral order doctrine jurisprudence, Congress has not deemed this doctrine to represent such a threat to the dockets of the federal courts as to require an amendment of Section 1291 to change the phrase "final decision" to "final judgment." *See Faragher v. City of Boca Raton*, 524 U.S. 775, 792 (1998) (noting significance of Congress' failure to amend statute); *see also* 28 U.S.C. § 1291 (amended by Pub.L. 85-508 (effective Jan. 3, 1959) and Pub.L. 97-164 (effective Oct. 1, 1992)). Once the collateral order doctrine requirements were fully satisfied, the Court of Appeals was compelled to accept jurisdiction of this case. 28 U.S.C. § 1291 ("*shall* have jurisdiction") (emphasis added).

While it is true that, in the criminal context, the Court has only found three examples of orders satisfying the collateral order doctrine requirements, the Court has never declined to review an order that satisfied the doctrine's requirements solely on policy concerns, such as a "floodgates" argument. For example, in *Behrens*, the Court of Appeals expressed concern that a second appeal on the issue of qualified immunity "would tend to have the illegitimate purpose of delaying the proceedings." 516 U.S. at 310. While recognizing that "[u]ndeniably, the availability of a second appeal affords an opportunity for abuse," the Court went on to note that they have no reason to believe that such abuse has often occurred. *Id.*

In the present case, the government itself recognizes that "there is no reason to think that collateral order appeals in future cases will place an unwarranted burden on federal appellate courts or will unduly disrupt criminal prosecutions." (Gov't Supp. Br. at 19). The government asserts that "[t]he universe of patients who are treated involuntarily with antipsychotic medication is relatively small." (*Id.*).[5] Regardless, if allowing such an appeal

[5] Moreover, even if that were not true and the government were making it a common practice to involuntarily medicate detainees, presumed to be innocent, then the need to set forth a clear standard to

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pursuant to the collateral order doctrine would result in a flood of new appeals, the courts of appeals already would be drowning. Since at least 1998 and, arguably, since 1991, an individual seeking to challenge an order authorizing involuntary administration of antipsychotic drugs has had authority that such an order falls within the contours of the collateral order doctrine. *See Brandon*, 158 F.3d at 950-51 (decided in 1998); *Weissberger*, 951 F.2d at 396-97 (decided in 1991). This is particularly true given the government's position that such orders are appealable under the collateral order doctrine. Further, the regulation pursuant to which the Bureau of Prisons seeks to forcibly medicate detainees to attempt to restore competence for trial has been in existence since 1995. 28 C.F.R. § 549.43. Nevertheless, despite this existing authority, no such flood of appeals has apparently occurred. Fortunately, it appears that circumstances as extreme as those presented by the case at hand are rare.

In any event, this Court has repeatedly recognized that "if and when abuse does occur, as we observed in the analogous context of interlocutory appeals on the issue of double jeopardy, 'it is well within the supervisory powers of the Courts of Appeals to establish summary procedures and calendars to weed out frivolous claims.'" *Behrens*, 516 U.S. at 310 (quoting *Abney*, 431 U.S. at 662 n.8). This Court also explained that "problems of delay can be obviated by rules or policies giving such appeals expedited treatment." *Abney*, 431 U.S. at 662 n.8. The government has recognized as much, explaining that reasonable steps can be taken to prevent frivolous claims and minimize any delay in any future cases involving the forced medication of an accused with antipsychotic drugs solely for the purpose of ruling him competent to stand trial. (Gov't Supp. Br. at 16-18). Thus, even to the extent that concerns as to frivolous claims and delay could justify rejection of

be applied in such cases is even more paramount to insure that fundamental constitutional freedoms are not being violated.

an order satisfying the collateral order requirements, in the context of the type of order at issue here, such concerns are purely speculative and can be addressed without depriving the accused of a meaningful review of these fundamental liberty interests.

CONCLUSION

The Court of Appeals had jurisdiction under 28 U.S.C. § 1291 pursuant to the collateral order doctrine, and this Court has jurisdiction under 28 U.S.C. § 1254(1).

Respectfully submitted,

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